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Canada. Social Security, Spec. Committee
1944
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SESSION 1944
HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 1

THURSDAY, FEBRUARY 24, 1944

WEDNESDAY, MARCH 1, 1944

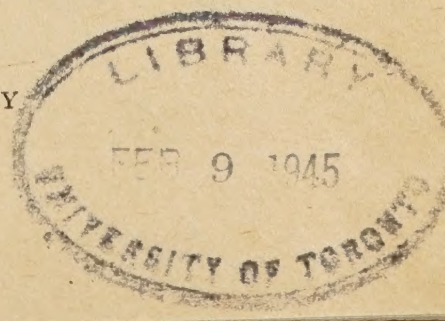
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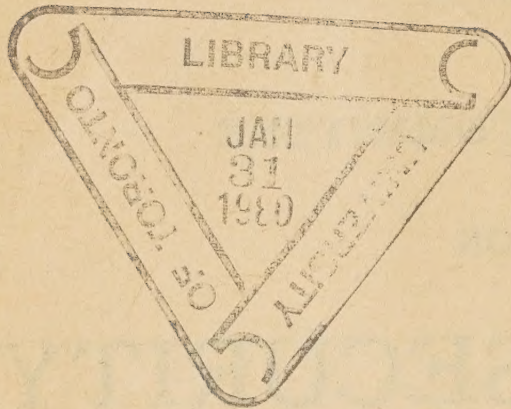
WITNESSES:

Hon. Ian Mackenzie, Minister of Pensions and National Health, Ottawa

Dr. J. J. Heagerty, Director of Public Health Services, Department of
Pensions and National Health, Ottawa

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944





ORDERS OF REFERENCE

HOUSE OF COMMONS,

FRIDAY, February 4, 1944.

Resolved,—That a select committee of this House be appointed to examine and report on a national plan of social insurance which will constitute a charter of social security for the whole of Canada, and, to that end,

To examine and study the existing social insurance legislation of the Parliament of Canada and of the several provincial legislatures; social insurance policies of other countries; the most practicable measures of social insurance for Canada, including health insurance, and the steps which will be required to effect their inclusion in a national plan; the constitutional and financial adjustments which will be required for the achievement of a nation-wide plan of social security; and other related matters.

That the said committee have power to appoint, from among its members, such subcommittees as may be deemed advisable or necessary to deal with specific phases of the problems aforesaid, with power to call for persons, papers, and records, to examine witnesses under oath, to print such papers and evidence from day to day as may be ordered by the committee for the use of the committee and members of the House; that the said committee shall report to the House from time to time; and that the said committee shall consist of the following members: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (Mrs.) (*Edmonton East*), Claxton, Cleaver, Cote, Diefenbaker, Donnelly, Fauteux, Fulford, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie, (*Vancouver Centre*), MacKinnon, (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, McIvor, Maybank, Mayhew, Mitchell, Picard, Shaw, Slaght, Veniot, Warren, Wood, Wright and that the provisions of Standing Order 65 limiting the number of members on special committees, be suspended in relation thereto.

Attest.

ARTHUR BEAUCHESNE,

Clerk of the House.

TUESDAY, February 29, 1944.

Ordered, That twelve members shall constitute a quorum of the said committee.

Attest.

ARTHUR BEAUCHESNE,

Clerk of the House.

REPORT TO THE HOUSE

THURSDAY, February 24, 1944.

The Special Committee on Social Security begs leave to present the following
as a

FIRST REPORT

Your Committee recommends that twelve members shall constitute a
quorum.

All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

MINUTES OF PROCEEDINGS

THURSDAY, February 24, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. The following members were present: Messrs. Breithaupt, Bruce, Casselman (Mrs.), Donnelly, Fulford, Gershaw, Howden, Hurtubise, Johnston (*Bow River*), Leclerc, Lockhart, Macmillan, McCann, McIvor, Mayhew, Picard, Shaw, Slaght, Veniot, Warren and Wright—21.

On motion of Mr. McIvor, seconded by Hon. Mr. Bruce, Hon. Cyrus Macmillan was unanimously elected chairman. Mr. Macmillan took the chair and expressed his appreciation of the honour conferred on him by the committee in re-electing him chairman.

On motion of Mr. Veniot, Mr. Blanchette was elected vice-chairman.

Mr. Howden moved that the following members who composed the sub-committee on agenda last year be re-appointed to that sub-committee this year; viz. Messrs. Macmillan (chairman), Blanchette (vice-chairman), Diefenbaker, Gershaw, MacInnis.

Motion adopted.

Mr. Hurtubise moved that the committee print from day to day 1,500 copies in English and 700 copies in French, of its minutes of proceedings and evidence, and such other documents as the committee may order.

Mr. Lockhart moved in amendment thereto that 1,500 copies in English and 400 copies in French of the minutes of proceedings and evidence be printed. The amendment was adopted.

Mr. Donnelly moved that the committee ask the house to reduce its quorum to 12 members. Motion adopted.

Mr. Slaght suggested that the chairman confer with the chairmen of other committees before arranging meetings so as to avoid conflicting with them. The chairman agreed to do this.

On motion of Mr. Donnelly the committee adjourned at 11.30 a.m. to meet again at the call of the chair.

WEDNESDAY, March 1, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (Mrs.), Cleaver, Côté, Donnelly, Fauteux, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Mayhew, Picard, Shaw, Slaght, Veniot, Warren and Wood—35.

The chairman announced that Hon. Mr. Mackenzie, Minister of Pensions and National Health, would make a statement.

Hon. Mr. Mackenzie addressed the committee with reference to the Physical Fitness Bill which was passed by the house last session. He then referred to the Health Insurance Bill and outlined the action taken by the government in compliance with the recommendations of the committee in its report dated July 23, 1943.

A copy of the 7th draft of the Health Insurance Bill was distributed to members of the committee and Mr. Mackenzie read to the committee the portions which had been changed, and gave reasons for the changes.

Mr. Mackenzie filed a copy of the recent white paper tabled in the British House of Commons (Exhibit No. 2). He then made a comparison between the British and Canadian financial plans. The minister concluded his statement and was thanked by the chairman.

Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, was called, examined and retired.

Mr. Howden moved,—

That organizations which have already submitted briefs and which may now wish to express a change of views or to give any other information to the committee, may submit their additional representations in writing by March 31 next. This also applies to other organizations which have not yet been heard who wish to present their views in writing.

Motion adopted.

On motion of Mr. Blanchette the committee adjourned at 12.30 p.m., to meet again at the call of the chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

March 1, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cýrus Macmillan, presided.

The CHAIRMAN: This morning we have a statement from the Minister of Pensions and National Health, Hon. Mr. Mackenzie.

Hon. Mr. MACKENZIE: Mr. Chairman and gentlemen, I want to thank the committee for the courtesy of permitting me to be their first witness this year as I was last year. If you will be good enough to refer to the report you made to the house during the last session, you will find that you recommended a physical fitness bill which was passed by the house. I just wished to refer to that incidentally before I go ahead discussing the master Health Insurance Bill. That bill was put in force by proclamation. It was proclaimed on the 1st day of November, and about two or three weeks ago we were organized and have now one from every province in Canada on the National Council on Physical Fitness. The members are as follows:—

W. A. Wellband, Esq., Regina, Saskatchewan.

Arthur A. Burrige, Esq., Hamilton, Ontario.

Dr. Jules Gilbert, Quebec, P.Q.

Jerry Mathison, Esq., Vancouver, B.C.

Joe H. Ross, Esq., Calgary, Alberta.

Dr. W. C. Ross, Halifax, Nova Scotia.

Minot Brewer, Esq., Fredericton, New Brunswick.

R. Wray Youmans, Esq., Winnipeg, Manitoba.

Major Ian Eisenhardt, Ottawa, National Director of Physical Fitness.

There are five provinces definitely in and two to come in as the situation stands at the present moment. Ontario has not signified her intention to come into the scheme as yet.

Now I should like to go ahead with a very brief discussion of the changes we are making. You will remember that in your report you recommended the principles of the health insurance bill of last year, but you, as a committee, also made certain recommendations to which I shall refer during the course of my very brief statement.

The Hon. Cyrus Macmillan, Chairman of the Special Committee on Social Security, presented to the House of Commons the fourth report of the Special Committee on Social Security on Friday, July 23, 1943. Among others the report contained the following recommendations relating to the draft health insurance bill which was presented to the committee by me on March 16, 1943:—

1. That before the bill is approved in detail or amended and finally reported, full information regarding its provisions be made available to all the provinces.

2. That to provide this information, officials of the various government departments concerned be instructed to visit the various provinces and to give full details of the proposed legislation to the provincial authorities.

3. That, if possible, before the next session of parliament a conference of representatives of the governments of the various provinces and the dominion be held to discuss certain complex problems involved, especially financial and constitutional questions.

4. That in the light of all the information meanwhile obtained, study of the bill be continued by a committee of the house and by the advisory committee on health insurance.

In compliance with the recommendations of the Special Committee on Social Security, the Advisory Committee on Health Insurance prepared information for the provinces entitled, "Data relating to the proposed plan of Health Insurance for Canada and National Physical Fitness." This publication contained a résumé of the draft health insurance bill, together with an explanation of each section and a summary of the financial aspects, as well as a précis of some of the submissions that had been made by various organizations, such as the Canadian Medical Association, the Canadian Public Health Association, the Canadian Dental Association, etc. Copies were forwarded to each province.

After considering the recommendation that officials should visit the provinces to advise the provincial authorities regarding the nature of the draft health insurance bill, it was concluded by the Advisory Committee on Health Insurance that the information respecting the financial aspects of the bill was not sufficiently complete to enable representatives of the Advisory Committee to indicate the costs and to place a definite proposal in regard to dominion and provincial contributions before the provinces and that, inasmuch as the Special Committee on Social Security had recommended that a conference of representatives of the governments of the various provinces and the dominion be held to discuss financial and constitutional questions, it would be better to await such conference before making any representations in respect of financial aspects of the draft bill. It was hoped that before such meeting the financial sections of the draft bill would be clarified and simplified.

In this respect, a special committee on finance, comprising a representative of the Bank of Canada, the Department of Finance, the income tax branch of the Department of National Revenue, the unemployment insurance division of the Department of Labour, and the vital statistics division of the Dominion Bureau of Statistics, has met continuously over a period of three months to study and report on all aspects of the financial sections of the draft bill. The committee presented the following report on the 28th of December, 1943:—

As a result of its study the committee is of the opinion:—

1. That the proposed methods of determining the contribution of the so-called "assessed contributor" would require cumbersome and expensive administrative machinery and, even then, would likely be unsatisfactory and might well prove quite unworkable.

2. That the proposed annual payment of \$26 per insured contributor is too high as a standard in that adjustment would be required for the majority of the contributors and a heavy financial burden on provinces would result. (The Census indicates that about 62 per cent of the wage earners in 1941 earned less than \$950 per year.)

3. That that part of the proposed plan seems unjust, under which the head of a family with a very low income would be made to pay a contribution representing a greater percentage of his income than was deemed advisable to collect from a single person with the same income.

4. That in a health insurance plan which envisages complete coverage it would appear inadvisable to require a special contribution from employers and that, in any event, the proposed employer's contribution being limited

to that portion of the employee's contribution not within his financial capacity to pay would, on the basis of the estimates presented, produce a comparatively small share of the cost and would on the whole fall on the small employer rather than the large corporations; that the substantial portion of the employer's contribution presumed to come from farmers using unpaid labour with living allowances would likely meet with serious opposition and would be doubtful of collection in large part, and that the provinces facing the greatest difficulty in financing health insurance would benefit least from an employer's contribution of the kind recommended in the draft provincial bill. It is also of importance that an employer's contribution of the type proposed adds directly to the costs of production and for this reason tends to discourage employment to some degree and to handicap Canada in international competition.

5. That if the dominion health insurance grant is to be given in large part for the purpose of making it financially possible for all provinces to join in the plan, the basic fact of the provinces uneven fiscal capacity, evidenced by their annual revenue and expenditure statements must be properly recognized. The provisions of the draft bill fail to take this uneven fiscal capacity into account.

The committee therefore recommended that the financial provisions of the draft bill be revised to provide a new basis of contribution on the following lines:—

1. That every person over sixteen years of age resident in the province shall contribute to the health insurance fund as follows:—

- (a) An annual flat contribution of \$12: that persons with dependents, other than those under sixteen years of age, be made responsible for the dependents' contribution and that regulations be prescribed to permit the abatement of part or all of this contribution for those who demonstrate their inability to pay; that it shall be the duty of the province to collect such contributions and where any such abatements are made the province shall be required to make up the deficiency: provided that where any province, after two or more years' operation of health insurance, can demonstrate its ability to provide health services of the required standard at a cost per insured person less than the dominion average, such province may reduce the flat annual contribution proportionately, but the \$12 amount shall be used for the purpose of calculating the dominion grant.
- (b) An amount based on the income of the person on the following bases:—
 - (i) For a single person, 3 per cent of his income over \$660 per year provided that such contribution in no case shall exceed \$30.
 - (ii) For a married person, 5 per cent of his income over \$1,200 per year provided that such contribution in no case shall exceed \$50.

This contribution would be collected by the dominion along with income tax. It would be based upon income as defined and assessed for dominion income tax purposes. It would be collected in the same way and at the same time as income tax but would be separately labelled and calculated in the income tax return. The contribution would be defined and levied in the dominion Act and apply to residents of those provinces taking advantage of the health insurance grant.

2. That the dominion shall contribute to the cost of health insurance in each province each year an amount equal to:—

The number of persons of all ages in the province entitled to receive benefits, multiplied by the estimated average per capita annual cost of benefits for all provinces;

Less the number of persons sixteen years of age or over entitled to receive benefits, multiplied by \$12;

And also less the amount collected by the dominion from residents of the province in the form of health insurance contributions based on income for that year.

In effect, therefore, the dominion will provide to the health insurance fund of each province the estimated total cost of benefits (on the average for all provinces) for children under sixteen years of age and the excess of that estimated average cost of benefits over \$12 per capita for those sixteen years of age and over, in so far as these amounts cannot be provided by the health insurance contributions based on incomes of residents of the province. This basis for the dominion grant provides an automatic and appropriate formula for determining fiscal need, and the use of average costs of benefits in all provinces leaves each province with practically a full incentive to keep down its own costs.

3. That the province shall pay the cost of administration of the Act and any excess of operational costs over the dominion average on which the dominion's contribution is based.

It is estimated that the costs of benefits would amount to about \$250 million a year, that the health insurance fees of \$12 per adult would amount to \$100 million, that the contribution of 3 per cent and 5 per cent based on income would amount to \$50 million, leaving about \$100 million to be provided by the dominion. The provincial governments would have to bear the cost of any of the \$12 fees abated, any excess of costs of benefits over the estimated average for all provinces and the purely administrative costs. You will see, therefore, that the cost to the provinces is very much less than it was under the scheme you were discussing last year.

It must be emphasized that these estimates are intended only to present a very general idea of the probable magnitude of the sums that would be involved.

As the financial recommendations contained in the report of the committee on finance were simpler, clearer and more practicable than those originally recommended by the Advisory Committee on Health Insurance, instructions were issued that the draft health insurance bill should be rewritten to conform to the new financial recommendations. This has been done and a new draft health insurance bill prepared for the consideration of this committee. In addition to rewriting the financial sections, other changes were made in the draft bill with the object of simplification and clarification.

The draft bill now being submitted is the seventh draft health insurance bill. It is noted that, whereas in the original draft bill submitted to the Special Committee on Social Security provision was made for the contribution from employers, employees, assessed persons, the dominion and the provinces, the present draft bill provides for contribution by the people, by the dominion and by the provinces, the contribution of the last named being confined to payment of the cost of administration and to compensation for abatements of contributions in the case of persons unable to contribute the \$12 a year for themselves and their adult dependents.

Health insurance was originally confined to employees and in early health insurance plans the contributors were the employee and the employer. Later, the contributors became tripartite, including employee, employer and the state. In national health insurance plans, as in the present bill, the tendency is to finance the plan by contributions from all citizens and the state. This is the case in New Zealand, Norway and Sweden. In addition to contributions of citizens and state, Denmark and Finland require a contribution from the employer. It is considered by those best informed in the field of economics that

contributions by the employer impose a burden upon industry by increasing the cost of production of goods thereby making competition with similar industries in other countries more difficult. Contribution by the employer lends itself to low wages, a low standard of working conditions, poor health, poor physique and consequent dissatisfaction on the part of both the employer and the employee. Contributions by the state are a necessity; otherwise insurance measures fail for lack of financial support.

It has been suggested that a completely free or non-contributory system should be adopted, but it is considered that such a system encourages the pauper mentality and may create a delusion that the public purse is bottomless, thereby encouraging extravagance and maladministration. It is more consistent with the dignity and independence of man that he should purchase the necessities of life with his own money. Under a contributory system of health insurance, benefit becomes a right and not a charity. Moreover, the beneficiaries who are contributors feel a sense of responsibility in regard to the cost of services and administrative procedures.

In revising the draft bill the short title was changed from "The Health Act" to "The National Health Act".

In the first section of the draft bill, generally referred to as the dominion section, the following additions have been made:—

1. The dominion government shall determine the average cost of health insurance for the first two years that a plan is in operation and shall contribute on that basis for that period. Following this period, the average cost will be determined every three years. The dominion government grant will be based on such determination. 3 (2).
2. Regulations may be made by the Governor in Council for determining the number of qualified persons and qualified adults in any province, the cost of health insurance benefits and the amounts expended by a province for general public health services set forth in the third schedule. 3 (5).
3. Pending final determination of the amounts payable to a province, the Governor in Council may make an advance payment to the provinces with the understanding that if the amount of such advance exceeds the amount actually payable, the surplus payment will be returned. 3 (6).
4. The Governor in Council may approve of administration by a provincial department of health in lieu of a commission. 4 (1).
5. Collection of statistics by the dominion statistician. 7 (3).
6. The Lieutenant-Governor shall appoint to the health insurance commission two members to be nominated by the Governor in Council. 11 (d).
7. Changes in the first schedule to conform to the new financial arrangements and to carry out recommendations made by the Special Committee on Social Security. In this schedule special provision has been made to enable a province to conduct a program for the prevention and treatment of crippling conditions in children.

In the course of revision it was found possible to reduce the number of clauses in the second schedule (Provincial Model Act) from 64 in the original draft bill to 48 in the present draft. In addition, schedules A, B and C of the original draft bill have been deleted as it was considered more practicable for the provinces to make provision for the content of such schedules by regulation.

In the second schedule (Provincial Model Act) sections 1 to 26 have been deleted and the following substituted therefor:—

SECOND SCHEDULE

(Section 4)

A Draft for a Health Insurance Act

His Majesty, by and with the advice and consent of the
Legislative Assembly, enacts as follows:

SHORT TITLE

1. This Act may be cited as The Ontario (or as the case may be)
Health Insurance Act, 194 .

INTERPRETATION

2. (1) In this Act and in any regulations, agreement or order made thereunder, unless the context otherwise requires,

- (a) "adult" means any person who has attained his sixteenth birthday and whose normal place of residence is in the province;
- (b) "commission" means the authority set up by the province, for the purpose of administration of this Act;
- (c) "juvenile" means any person who has not attained his sixteenth birthday and whose normal place of residence is in the province;
- (d) "minister" means the Minister of Health;
- (e) "prescribed" means prescribed by regulation of the commission (Lieutenant-Governor in Council);
- (f) "regulation" means regulation made pursuant to this Act.

(2) In this Act and in any regulations, agreement or order made thereunder, unless the context otherwise requires, each of the following expressions shall have the meaning assigned thereto in the section of this Act cited in this subsection:—

- (a) "contributor," section 5;
- (b) "health insurance books," section 7;
- (c) "health insurance cards," section 7;
- (d) "health insurance fund", section 9;
- (e) "health insurance stamps, section 7;
- (f) "income", section 6;
- (g) "medical practitioners", section 11;
- (h) "qualified person", section 3.

PERSONS COVERED BY THIS ACT

3. (1) Every adult in whose case the requirements of the Act are complied with by him or on his behalf and every juvenile of whom he has for the time being the care and control shall be qualified to receive the benefits of health insurance conferred by this Act.

(2) A person who is qualified to receive the benefits of health insurance conferred by this Act may be referred to as a "qualified person."

(3) The commission shall prescribe the terms and conditions under which a qualified person may obtain his health insurance benefit while temporarily outside the province.

REGISTRATION

4. (1) Every adult shall, on or before a prescribed date, file with the commission a return in prescribed form and manner and containing such information as may be prescribed, for the purpose of enabling the commission to establish and maintain a register of qualified persons and for other purposes of this Act.

(2) Every person who files a return shall answer promptly any inquiries of the commission concerning any entry in the return or concerning any omissions therefrom, and the commission shall make such other inquiries as may appear necessary to ascertain the correctness of the return and of any information obtained as a result of any such inquiry.

(3) The commission shall not be bound by any entry in any such return nor by information obtained as a result of any inquiry as aforesaid.

CONTRIBUTORS

5. (1) Except as provided in this section and section 6 of this Act, every adult shall pay to the health insurance fund a contribution of twelve dollars in each year in such manner and at such time and place as may be prescribed.

(2) An adult who is wholly dependent on another adult for support shall not be required to pay the contribution mentioned in subsection 1 of this section, but the person on whom he is dependent shall, in addition to the contribution required to be paid by him, pay to the health insurance fund a contribution of twelve dollars on behalf of the dependent adult in each year he is so dependent.

(3) Where an adult is partially dependent on another adult for support, or is wholly dependent for a period less than a year, the commission may prescribe the amount of the contribution to be paid by each of such persons.

(4) The commission may by regulation prescribe the persons or class of persons who shall for the purpose of this section be deemed to be dependents.

(5) Persons who are required by this section to pay a contribution may be referred to as "contributors".

ADJUSTMENT OF CONTRIBUTIONS

6. (1) Where the income of a contributor is less than an amount prescribed, the contribution otherwise payable by him under section 5 of this Act may, upon application, be reduced by such amount as the commission may determine in accordance with prescribed regulations.

(2) The commission may make regulations prescribing the manner in which the income of any person shall be determined for the purpose of subsection 1 of this section.

(3) The provincial treasurer shall, out of any unappropriated moneys forming part of the Consolidated Revenue Fund, pay into the health insurance fund sums equal to the amounts by which contributions have been reduced under subsection 1 of this section.

(4) An appeal may be made by any person against the findings of the commission in respect of the determination of his income for the purposes of this section.

(5) The commission may make regulations prescribing the time and manner of making appeals, the constitution of the authority to hear and decide appeals and the procedure at and concerning appeals, and any decision made by such authority shall be final and conclusive and not subject to review.

METHODS OF PAYMENT

7. (1) Subject to the provisions of this Act, the commission may make regulations providing for any matters relating to the payment and collection of contributions payable under section 5 of this Act, and in particular for

- (a) specifying the manner, times, and conditions in, at and under which payments are to be made;
- (b) requiring employers to collect from their employees the contributions payable by the employees under section 5 of this Act, by deductions from salary or wages or otherwise and to remit the amounts collected to the commission;
- (c) the entry in or upon health insurance books or cards of particulars of contributions paid in respect of the persons to whom the health insurance books or cards relate;
- (d) the issue, sale, custody, production, and surrender of health insurance books or cards and the replacement of health insurance books or cards which have been lost, destroyed, or defaced; and
- (e) the offering of reward for the return of a health insurance book or card which has been lost and for the recovery from the person responsible for the custody of the book or card at the time of its loss of any reward paid for the return thereof.

(2) The commission may by regulation provide for the payment of contributions, and of contributions in arrears, by means of stamps (in this Act referred to as "health insurance stamps") affixed to or impressed upon books or cards (in this Act respectively referred to as "health insurance books" and "health insurance cards") or otherwise, and such stamps or the devices for impressing the same, or other methods of payment, shall be prepared and issued in such manner as may be provided by the regulations.

(3) The commission may by regulations provide for the issue, custody, production, cancellation and surrender of stamps, and may enter into an agreement with the Postmaster General of Canada, or such other persons as may be prescribed, for the sale of stamps.

REFUND OF CONTRIBUTIONS

8. Where a contributor pays money to the health insurance fund under section 5 of this Act in excess of the contributions he is by that section required to pay, a refund of such excess amount may be made to him, under such terms and conditions as the commission may prescribe, if such excess amount is not less than fifty cents.

HEALTH INSURANCE FUND

9. (1) There shall be a special account in the Consolidated Revenue Fund of the province called the health insurance fund (in this Act referred to as "The Fund"), to which the provincial treasurer shall from time to time credit

- (a) all contributions paid under this Act;
- (b) penalties payable to the fund;
- (c) all grants made to the province by the government of Canada for the purposes of this Act and all payments made under subsection 4 of section 3 of the National Health Act, chapter . . . of the statutes of Canada, 1944, to the province by the government of Canada based upon the health insurance contributions payable under Part . . . of the Income War Tax Act, chapter 97, of the Revised Statutes of Canada, 1927;

- (d) any sums payable to the fund out of the revenues of the province under the terms of this Act or otherwise together with any other sums received on behalf of the fund;
- (e) interest earnings on any investments of the fund.

(2) The provincial treasurer may, subject to the provisions of this Act and to any regulations made thereunder, on requisition of the commission or its authorized officers, pay out of the fund any sums which may be required to pay the costs of the benefits of health insurance conferred by this Act.

(3) Regulations may be made hereunder for the purpose of

- (a) authorizing the appointment of a committee, with powers defined by the regulations, to invest from time to time any part of the fund not currently required for the purposes of this Act and to sell or exchange investments so made for other like investments; and
- (b) making effective the intentions of this section.

Sections 27 to 65 have been renumbered as sections 10 to 48, and minor changes made therein in the terminology with the object of simplification. Such changes do not constitute a radical departure from the phraseology and terminology of the original draft bill. I have read only such sections of the draft bill as constitute a definite change from the original.

The new draft bill makes provision for health insurance for everyone irrespective of income, thereby bringing adequate medical care within the reach of all. It will protect families against the hazard of illness and offer protection to motherhood and childhood. It will encourage the eradication of tuberculosis and the venereal diseases and will help to reduce mental illness, the incidence of heart disease, arterial disease, kidney diseases, diabetes, cancer and diseases of middle life. It will help to extend public health services throughout the country—federal, provincial and local. It will enable the medical and other professions to attack the cause of sickness and death vigorously and effectively. I, therefore, submit it to you, Mr. Chairman, Mrs. Casselman and gentlemen, with confidence in the knowledge that it will provide Canada with an advanced form of preventive public health services and medical care that cannot but have a lasting effect in improving the health of the people of Canada.

Copies of "Data relating to the proposed plan of health insurance for Canada and national physical fitness" and the draft health insurance bill have been distributed to you.

With your permission, gentlemen, I want to very briefly clarify further the financial provisions.

The Dominion will contribute an amount equal to the total population of each province multiplied by the per capita cost, which tentatively is set at \$21.60.

Less the number of persons sixteen years of age or over multiplied by \$12,
Also less the amount collected through income tax machinery.

For example:

Taken on the basis of the census of 1941, the total population of all provinces multiplied by the per capita cost would amount to somewhere in the neighbourhood of		\$250,000,000
Deduct from this the \$12 contribution of adults, which would be roughly.....		100,000,000
		<hr/>
		\$150,000,000
Deduct from this the total amount to be collected by the dominion through the income tax machinery on behalf of the provinces, which would be roughly.....		50,000,000
		<hr/>

Leaving an amount to be contributed by the dominion from general taxation of, roughly.....\$100,000,000

The dominion will make full payment for all children under sixteen years of age and will contribute the difference between \$12 and \$21.60 for adults less the amount collected through the income tax machinery.

The provinces will be required to make up any abatement of the \$12 contributions for those who are unable to pay, which on the best estimates would not exceed \$15,000,000 and which is about the amount the provinces and municipalities were required to pay for indigent medical care in 1941. In addition to this, the provinces will pay for administration. This was originally estimated at 10 per cent of per capita cost (\$21.60) or \$2.16 per capita. The committee on finance believes this estimate of 10 per cent is too high and that the figure will be nearer 5 per cent, or \$1.08 per capita.

I have here the recent white paper tabled in the British House of Commons. It just came in yesterday. This is the only copy I have but I am prepared to leave it with the committee for the information of hon. members who may wish to read it. It is the first copy that has come in.

Now, I would like to make a brief comparison between the financial bases of the proposed British plan and ours. The new health insurance plan in Great Britain is as follows: Annual cost of health insurance, 147·8 million pounds which represents \$657·7 million, on the basis of \$4.45 to the pound. The per capita cost on 41,460,000 people is \$15.86.

This is financed, according to the white paper, as follows: Exchequer grants, 94·4 million pounds or \$420·1 million and the per capita amount from the Exchequer is \$10.13; from the local authorities there is a total of 53·4 million pounds or \$237·6 million or a per capita contribution from the local authorities of \$5.73; making a total, per capita, of \$15.86.

The Exchequer grants are broken down as follows: direct grant, doctors and drugs, a total of 33·4 million pounds or \$148·6 million, and a per capita of \$3.58; hospitals general (municipal, voluntary, mental and infectious disease) 43·4 million pounds, \$193·1 million and per capita \$4.66; home nursing and dental (total cost £18 million), 9 million pounds, \$40·1 million, per capita, .97; 50 per cent estimated increased cost over standard year, 8·6 million pounds, \$38·3 million, per capita, .92. That makes a total per capita of \$10.13, as I mentioned a few moments ago. Exchequer grant to hospitals: £100 per bed for general hospitals—\$1.25 per diem. £35 per bed for mental and infectious disease hospitals—\$0.42 per diem.

Now, let us compare that briefly with what I believe to be the number of proposals for new construction here.

The new health insurance plan in Canada: estimated annual cost of health insurance, approximately, \$250 million; estimated per capita cost of all benefits \$21.60, which is subject to revision.

Dominion Grants, estimated \$100,000,000; contribution by people to provinces, \$100,000,000; contribution by people through income tax \$50,000,000, making a total of \$250,000,000.

Provincial contribution—cost of administration (5 per cent of cost of benefits), and abatement of contribution for those unable to pay full amount. These estimates are approximate and intended only to present a general idea of the sums involved. Finance Committee is continuing studies of cost.

That is all I have to say by way of introduction. As I say these are just departmental proposals; there is nothing rigid or final about them. This bill has not been considered by the government; it is purely the work of these committees with some little assistance by myself. It is the result purely of the complete, capable and adequate discussions of this committee without any direction whatsoever from governmental authorities with regard to what policies this committee should recognize. Now, on the draft bill which you have before you, in pages

2 to 10, the amounts have yet to be filled in, and the Finance Committee is working on that now, by way of recommendation, and that material will be coming through to this committee at an early date.

This is a brief study of the proposals set before this committee for its consideration and such action as the committee may wish to take in its good judgment.

The CHAIRMAN: Thank you, Mr. Mackenzie.

Mr. JOHNSTON: Do I understand that the report the minister has given is a summary of a report of the Finance Committee?

Hon. Mr. MACKENZIE: The actual report of the Finance Committee.

Mr. JOHNSTON: The complete report?

Hon. Mr. MACKENZIE: Yes.

Mr. JOHNSTON: I understand you to say it is a summary?

Hon. Mr. MACKENZIE: Well, some of these people are present here, and we could ask them.

Mr. JOHNSTON: Is it a summary of the report or is it the report?

Dr. HEAGERTY: Perhaps I might call on Mr. Howes.

Mr. JOHNSTON: I wonder if we could have the facts?

Mr. J. E. HOWES: I would say that is a summary of the report.

Mr. JOHNSTON: Could the report be put into the evidence of the committee?

Hon. Mr. MACKENZIE: There is no objection to that. It has been changed from time to time, and that is why it was not filed today in toto, but it will be filed soon.

Mr. JOHNSTON: And it will be included in the proceedings of the committee's report?

Hon. Mr. MACKENZIE: I see no objection to that.

Mr. BRUCE: I asked the minister if I understood him to say a few moments ago that the representatives of the department or the advisory committee had not yet advised the provinces or acquainted them with the terms of this proposed bill.

Hon. Mr. MACKENZIE: No. The reason is that we had made arrangements for that to go out to the provinces, and then the financial provisions were being recast, and it thought wiser to wait until the report was received and considered; and now there will be a provincial conference with the provinces in the future when all these proposals will be discussed.

Mr. KINLEY: I take it that the intent is to secure enabling legislation and not to change the British North America Act for the purposes of this legislation?

Hon. Mr. MACKENZIE: I am personally strongly convinced that it is impossible to change the British North America Act in regard to health in Canada at the present time. That is my conviction. That is why the only feasible way that I can see is to do this by cooperation, by grants and by the method here. The burden is taken off the provinces drastically. Last year the financial proposals were sometimes thought to be too heavy on the provinces. Premier Garson of Manitoba was here and gave an excellent presentation, and I was in substantial sympathy with what he said. The cost to the provinces is less than under the draft as submitted last year. Now, there may be other aspects of the financial proposals that may be challenged and criticized, of course, and it is all right to

do that here, but I do think that in Canada—and it is entirely unlike unemployment insurance—there are certain conditions and circumstances with regard to health administration which do not lend themselves to rigid centralization.

Mrs. CASSELMAN: Is there a provision whereby one province might adopt this before other provinces or whereby a certain number might put it in force even if one or two did not take it up?

Hon. Mr. MACKENZIE: That is not definitely established yet. There is no doubt at all that the government would have to consider that carefully—whether it would do as in the case of the Old Age Pension Act, where in that case the province of British Columbia was the first province to adopt the Act and had the benefit of the old age pension while the rest of Canada did not come in for several years. It might be that we would require at least three or four provinces to come into the scheme or we might do the same as we did in the case of old age pension and start with one province. It is a matter which has to be determined yet.

Mr. McCANN: I would like to ask whether the changes in these two bills were made after representations by any of the provinces or without consultation with any of the provincial authorities with reference to the changes?

Hon. Mr. MACKENZIE: No. These changes were made on recommendation of the Advisory Committee after carefully reviewing the financial provisions of the draft proposals which were before this committee last year. And then we called in five of the ablest experts of the public service in Ottawa, and they carefully reviewed the formal proposals with the complete concurrence of Mr. Watson and with his assistance. But with regard to the report, a summary of which I gave this morning, they thought they would defer consultation with the provinces until this report was complete or unless we can arrange for a conference with the provinces.

Mr. McCANN: Is it proposed that there should be a visit by officers of the department to the provinces prior to having a consultation with the provincial premiers or their representatives here with respect to the bill?

Hon. Mr. MACKENZIE: I do not think so, doctor. I think what will be done is that we shall have a meeting of the Dominion Health Council when the provincial ministers of health or their deputies come here to discuss the new proposals which I outlined this morning, and that will be followed later on, perhaps by the Dominion Provincial Conference. It is not proposed now to send anyone from here out to the provinces.

Mr. KINLEY: As I listened to you reading, I got the impression that you were going to give more liberty in the provinces in the setting up of their organization, and that the minister of health, or the health department of the provinces who represent the people might be in the field, perhaps, more than the commission, who would be responsible?

Hon. Mr. MACKENZIE: That is an alternative which is entirely up to their judgment and decision.

Mr. Wood: Is there any provision made with regard to objections from certain religious institutions where health matters enter into their cult?

Hon. Mr. MACKENZIE: No, there is no reference whatsoever in the federal bill to that situation. We have had discussions with these religious groups who have some reservations as regards orthodox medical theory, and what we told them was this was entirely up to the provinces and we told them to make representations to the provinces when the provinces are enacting their bills. My own personal stand is that wherever these people have rights now those rights should not be interfered with in any province.

Mr. MACINNIS: Does the \$250,000,000 include the cost of all health services under this Act, or is it approximate?

Dr. HEAGERTY: No, the public health services are not included therein. They are in addition to that amount. If you refer to page 10 of the bill you will find listed there a number of public health services; the amounts have not yet been indicated.

Hon. Mr. MACKENZIE: They are straight grants from the federal government to the provincial governments and those grants are not available to any province that does not avail itself of the national health bill.

Dr. HEAGERTY: Some time will be given to the provinces to adopt the grants, with the exception of the public health grant which will become operative as soon as the bill is adopted by a province.

Mr. WARREN: With reference to the question raised by Mr. Wood, I understand that the Christian Science people have changed their recommendation of last year and desire to make a brief presentation to the committee this year. Will they be permitted to appear before the committee?

The CHAIRMAN: That is entirely a matter for the committee to decide. My understanding last July was that representations had been closed. We heard 117 witnesses last year, and we said that if there was no additional evidence to be presented nobody else would be heard. Now, I understand that the Christian Science group desire to make a change in the brief they presented last year, and my own judgment would be that they should be permitted to do that. That is a matter for the committee to decide, however. The danger lies here that if we accept additional evidence from one person or group of persons the probability is that we will have to accept additional evidence from others if they wish to make certain representations, and the result would be a very long drawn out discussion with the hearing of further evidence. However I would like to see the Christian Science representatives present any additional evidence which they wish to present.

Mr. BREITHAUP: As the minister points out it is a matter that concerns the provinces; therefore, why is it necessary to have them heard at all?

Dr. HEAGERTY: Mr. Chairman and gentlemen, a group of Christian Scientists interviewed me in my office, and I pointed out to them that no exemption could be made in so far as contributions were concerned, that it was not only a question of medical care but also of prevention, and that the contributions were needed for prevention as well as treatment. They said they were quite agreeable to contribute on the same basis as others and did not ask any exemption on that basis, but they feared that they might be forced to accept some of the benefits of which they did not approve according to their religious views. I asked them to draw up a clause to be included in the draft bill exempting them from the acceptance of the benefits, and they did so, and by agreement with them it was submitted to the Justice Department for consideration. The Justice Department pointed out that the Christian Scientists were not obliged to accept any of the benefits in the bill, and that the inclusion of a clause to that effect was redundant and absolutely unnecessary. They interviewed me subsequently, and I pointed out to them the view that had been expressed by the Justice Department. In addition I submitted their request to the members of the Advisory Committee in writing. Each member of the Advisory Committee thought it would be inadvisable to exempt any group from contributing. Also our legal adviser, Mr. Gunn, pointed out that the inclusion of a clause exempting Christian Scientists from the acceptance of benefits would be redundant, as they were not compelled to accept benefits. They then asked me if the dominion would agree to pay a

fee to their practitioners, but I was unable to come to any finality in that respect. I pointed out that their healers prayed over the sick, and that if a payment were made for that purpose we might be obliged to make a payment to the members of other religious bodies when they visited the sick and prayed for them. However, I suggested to them that they discuss the question of payment with the provinces because the dominion had, apparently, exhausted all possibilities in that direction.

Mr. BRUCE: I am not quite clear as to whether or not you indicated that you proposed accepting another brief from one organization, but if so I would like to point out that it would open the way for other organizations to appear.

The CHAIRMAN: I pointed that out, Dr. Bruce; but I also pointed out that if they cared to submit a written statement with regard to any changes in their views, different from their submission of last year, that I think such a statement should be accepted.

Mr. BRUCE: I would claim the same right for the Canadian Medical Association.

The CHAIRMAN: Certainly.

Mr. BRUCE: And, of course, for any others.

The CHAIRMAN: But no other representations.

Mr. McCANN: I suggest that the matter be left to the chairman and the agenda committee whether a brief be submitted in writing or whether these people appear in person.

The CHAIRMAN: Dr. McCann, I do not think that matter should be left to the agenda committee or to the chair; I think it would be better for the committee to decide whether we should accept any further oral representations but to accept amendments in writing in addition to any brief they may have submitted earlier.

Mr. MACINNIS: I think that would be the better way to proceed. There would be no objection to any organization which appeared before us last year amending its report or its presentation in writing.

Mr. ADAMSON: And the amended reports could be included in the transcript of the evidence?

Mr. BRUCE: I think we have heard enough evidence.

Mr. COTE: I would be interested to know whether the medical profession of the province of Quebec has made any representations since our adjournment last year. I understand that a certain opinion has spread among the medical profession in the province of Quebec which is not absolutely in accord with the representations which their heads of the medical society made before the committee here last year. I would be interested to know whether any representations have been received.

Hon. Mr. MACKENZIE: None has been received by me that I can recall.

Mr. FAUTEUX: Did you receive any representation from Father Bouvier, who appeared before the committee last year, and who I am informed entertains different opinions from those he expressed last year?

Dr. HEAGERTY: Father Bouvier has made representations to the committee. It is the view of the social service group in Quebec that all of the people should not be included in health insurance. There is an idea that the people of the cities with income up to \$1,200 should be included and that the people in the country districts with income up to \$1,000 should be included. I discussed the matter with him and pointed out that the exclusion of large groups of people

in the province of Quebec would be a disservice to the people of Quebec in that the prevention of disease played so important a part in the plan. I mentioned to him the high infant mortality and maternal mortality rates in Quebec and expressed the opinion that, unless all of the people in Quebec were included, the reduction of mortality, both maternal and infant, and from tuberculosis and other diseases, would progress at a rate much slower than in the other provinces which adopted the measure in full. I think that is principally the discussion that we had.

Mr. McCANN: Did Father Bouvier give any reasons why he wished the Act limited to persons in the income brackets mentioned?

Dr. HEAGERTY: With Father Bouvier it was a sociological question. He expressed the opinion that people with large incomes are capable of providing service for themselves and their children and that no compulsion should, therefore, be imposed upon them for themselves, their wives and their children.

Mr. ADAMSON: You said that in 1941 62 per cent of the people earned less than \$950 a year?

Dr. HEAGERTY: Yes.

Mr. ADAMSON: Has the committee made any estimate of what the figure would be now?

Dr. HEAGERTY: The census of 1941 is the last census made. I doubt if it would be possible for the committee at the present time to make a later estimate without a special study in that field in estimating populations and costs. Studies are usually made on the basis of census figures.

Mr. ADAMSON: Do you regard the census figures of 1941 as sufficiently advanced or sufficiently accurate for the purposes of this bill?

Dr. HEAGERTY: Yes.

Mr. SHAW: With regard to the matter of representations, would it be said that that matter was made abundantly clear last year that all interested organizations would have to make representations before the close of our meeting, last year? Personally, I feel that if justification is shown for other presentations I should give favourable consideration to that matter.

The CHAIRMAN: Last year every organization that asked to be heard was heard.

Mr. SHAW: Yes, but the point I had in mind, Mr. Chairman, was whether that was made sufficiently clear publicly that representations would have to be made, say, by the end of July last year?

The CHAIRMAN: It was made sufficiently clear that we were ready to accept representations at any time; that is as far as we could go. It was a well established fact that the committee was willing to hear any representations.

Mr. HOWDEN: On that point of additional amendments or submissions, have we cleared up that point or does it require to be cleared up by a motion?

The CHAIRMAN: It requires to be cleared up.

Mr. HOWDEN: To clear the matter up I would be glad to move that additional submissions be received by this committee in writing.

Mr. MACINNIS: I second that motion.

Mr. KINLEY: We find people to-day who have a different opinion on these matters from the opinions submitted by the organizations, and I do think they should enlighten this committee on how intelligent a canvass they have made of their organizations to see what they really did want. In the part of the country

from which I come there is a great difference of opinion with regard to the provisions, and there are people who stand in need of considerable education with regard to this matter.

The CHAIRMAN: Dr. Howden's motion, as I understand it is this. Last year we received certain representations from certain organizations. We heard everybody who asked to be heard. Now, then, certain of these organizations state that they have additional views to present, or that they have changed their opinion in the months which have elapsed. Dr. Howden's motion permits these people to submit a statement of those changes or additions if they so desire in writing.

Mr. KINLEY: I think that is a good motion.

The CHAIRMAN: Mr. MacInnis has seconded that motion.

Mr. KINLEY: We have changed the bill and it seems to me that when you change your proposed bill that anybody who made a representation before should be heard again.

The CHAIRMAN: That is covered by Mr. Howden's motion.

Mr. DONNELLY: Is there any organization that has asked to be heard that has not been heard?

The CHAIRMAN: No.

Mr. DONNELLY: Do you know of any who want to be heard?

The CHAIRMAN: I only know that the Christian Scientists would like to submit additional evidence embodying a change of viewpoint.

Mr. JOHNSTON: With regard to the submission of further evidence I do not know whether it is fair to exclude anyone else from making presentations before this committee, if you are going to allow these people to make further presentations in writing.

The CHAIRMAN: On a change of viewpoint.

Mr. JOHNSTON: Just because they happen to change their viewpoint does that give them the right to make two submissions where somebody else probably did not make a representation last year but may desire to do so this year? That seems to be taking rather an unfair advantage in the matter.

The CHAIRMAN: Will you bear in mind that these organizations referred to had provision made to hear them if they so desired and they did not express any such desire.

Mr. JOHNSTON: Yes. But was it made sufficiently clear to the public?

The CHAIRMAN: Yes.

Mr. JOHNSTON: We as members of the committee may have understood that quite clearly, but I doubt if the public generally were of that impression—the impression that no submissions would be received after July of last year.

The CHAIRMAN: No. The public were made aware of this fact that the committee had met to hear representations and that any organization which wished to present a brief would be permitted to do so. Now, surely the committee is not expected to go out into the highways and by-ways and to say: Do you want to come and speak to us? Those people know through the press what the committee is prepared to do. I think the committee has done everything in its power to publicize its methods.

Mr. JOHNSTON: Yes, that may be very true, and the committee did express the desire to hear these representations from anyone who wished to make them,

but there was no cut-off date given. If the committee were to state when the cut-off date was to be I do not think that would be considered as going out into the highways and by-ways to solicit presentations. I do not think that could be construed that way.

The CHAIRMAN: May I ask if you have any organization in mind who would like to submit a brief?

Mr. JOHNSTON: I have had it mentioned to me, but I am not definite whether they wish to present a brief or not. What I have in mind is this, that if there are organizations or individuals who want to make a presentation, they should not be excluded if at the same time we are going to allow those who have already made presentations to make further presentations in writing.

The CHAIRMAN: I suggest that if they submit their brief to the agenda committee that committee can decide whether or not it will be in the interests of the bill or the committee to have them heard. My suggestion would be that they should be heard within the next two or three weeks.

Mr. BRUCE: Should they be heard or should they submit a statement?

The CHAIRMAN: Submit a brief. A new organization should submit a brief and if we think we would like to talk with them we can ask them to come here.

Mr. BRUCE: I do not know when we are going to reach any finality. I sat here listening to 117 witnesses, and I think that if we are ever going to get on with this bill we must proceed more rapidly than we are doing at present; and I would oppose further representations being made. I think publicity was given to the fact that we were sitting and that anyone who wished to make a presentation to us was invited to do so. I do not believe that we need to go further in that regard. I would therefore be opposed to any more delay being caused by listening to any further representations from anybody.

Mr. LOCKHART: I just wish to add one word, Mr. Chairman. I am in accord with Mr. Howden's resolution, but I say advisedly that there was an impression abroad in parts of the country that there was possibly to be an amendment to the British North America Act which would probably make this thing possible. That seemed to be the impression that certain groups had. Perhaps that might have been the reason for the delay with regard to some organizations which Mr. Johnston seems to have in mind. But I do say definitely that there was an impression that such a course would be necessary. Now the minister has made it quite clear that, in his opinion—and I think his opinion is valuable—no change would be effected in the British North America Act, that it would not be practicable so to do. But I point out that there has been that impression abroad, and therefore it may be that this thing would not have been concluded so quickly as it has been, had it not been for that impression.

Mr. COTE: I support the motion of Mr. Howden, but I concur in the remarks of Mr. Bruce. I feel that if we were to accept written presentations from public bodies which have not appeared before the committee, it would not delay the committee very much. I would suggest that a statement be given to the press inviting these written presentations, in order that it may not be said later that the committee tried to curtail any of these submissions.

Mr. LOCKHART: Those presentations to be in by a definite date.

Mr. COTE: Yes, by a definite date.

Mr. LOCKHART: Then you would cover the situation.

The CHAIRMAN: What date would you suggest?

Mr. COTE: I would suggest that you make it clear to the public by a statement to the press that the committee is open until such and such a date for any written additional or new evidence.

Mr. BRUCE: I was speaking only of having additional witnesses here. I have no objection to what you have just suggested.

Mr. COTE: That is why I concur in your views. I think that new witnesses would delay the committee a great deal.

Hon. Mr. MACKENZIE: Yes.

Mrs. CASSELMAN: There are differences that are suggested in the draft bill which the various bodies which presented their views last year would no doubt like to take under consideration. Would those changes alter their submissions?

Hon. Mr. MACKENZIE: In some cases they would, I should think.

The CHAIRMAN: I am informed that they probably would affect their presentations.

Mrs. CASSELMAN: I should think we ought to have additional presentations in writing.

The CHAIRMAN: If so desired.

Mrs. CASSELMAN: If so desired, rather than in person.

Mr. JOHNSTON: Mr. Chairman, I do not want to dwell too long on this matter, but I do not think it is very satisfactory to just have these submissions put in writing. I do not see that it would take up any more of the committee's time if these presentations were made in person than it would if they were made in writing. It is very unsatisfactory, I think, to have these submissions made in writing and just included in the minutes of the proceedings; because, as a rule, you do not get the same benefit out of it as you do if the presentation is made personally. Remember what happened last year when Hon. Mr. Garson, the premier of Manitoba, desired to come before this committee. He was speaking to the reconstruction committee. He was stopped there and told that he should make his presentation to the social security committee. Then the social security committee refused to have him appear here, but did admit the evidence to be included in the proceedings. I am quite sure that the committee has not received as much value from Hon. Mr. Garson's presentation which was just included in the proceedings, as they would have had he been here and spoken in person. I do not think that method of procedure would help us a great deal; in fact, I doubt it very much.

Mr. MACINNIS: This is the second session during which we have had this measure before us. The people throughout the country, I think, are much more concerned that we should go ahead with a health insurance bill than that we should stay here in order to hear representations from various bodies. I am satisfied that we shall be far more subject to criticism if we delay this bill another year than will be the case if we refuse to hear oral representations from interested organizations. The representations that may be made in writing, either amending the representations that are already made or making new representations, can be summarized to the committee by the chairman or by the secretary, and we shall be able to judge as to whether there is anything of pertinent value in them. I agree with Mr. Bruce entirely, that we have given every opportunity for interested parties to put their cases before the committee, and should now proceed with discussion and consideration of the bill.

Mr. SHAW: Mr. Chairman, the changes in the draft bill would warrant the acceptance of additional representations, and I contend they would warrant the acceptance of new representations; so if we are not going to hear from any

further organizations, I would urge that we hear nothing more from those who have already made their representations. Let us be perfectly fair about it. As I said a moment ago—and let me reassert it—if the changes warrant additional representations, they may warrant new representations from organizations which may feel more justified now than they did before in the hearing.

Mr. ADAMSON: This is an open committee. I want to concur in what Mr. MacInnis said. If there is anything that some organization took violent exception to, surely they can make their objection known to us in writing; and if it is of such a violent nature, we can discuss it in committee.

The CHAIRMAN: And if we care to, we can call on them to appear.

Mr. ADAMSON: Yes; if we care to call the witnesses, I think we should be allowed to do so.

The CHAIRMAN: You have heard Dr. Howden's motion, seconded by Mr. MacInnis.

Mr. CLEAVER: Could we hear that motion before we vote on it, Mr. Chairman?

The CHAIRMAN: The motion is to the effect that organizations which already have submitted briefs and which may now wish to express a change of views or to give any other information to the committee, may submit their additional representations in writing.

Mr. LOCKHART: By a certain date, Mr. Chairman.

The CHAIRMAN: By the 15th of March?

Mr. LOCKHART: Oh, no. That is only fifteen days. That is not enough.

Mr. BREITHAUP: That does not give them quite enough time. We have spent a lot of time on this, but I do not think we should make the time so short. We all want to get on, but I would suggest the 31st of March.

Mr. MACINNIS: Yes, I think so.

The CHAIRMAN: Then, let us say March 31.

Mr. JOHNSTON: I understand from the wording you have given there, Mr. Chairman, that it excludes everybody else.

The CHAIRMAN: No. I was coming to that when I was interrupted. The motion also includes other organizations that have not yet been heard but who wish to present their views in writing.

Mr. CLEAVER: Would it then rest within the authority of this committee to call witnesses?

The CHAIRMAN: Yes, if the committee is of the opinion that their presence is necessary. That is correct.

Mr. MAYHEW: What would be your position if, after you have discussed this bill, you have the provincial authorities come down, you discuss the bill again and find that, in order to meet their requirements, you have to change the bill again? Would you want to go ahead again and re-hear it?

The CHAIRMAN: No.

Mr. MAYHEW: I think you have to bring this thing to a stop at some point, if you are going to get the bill through.

The CHAIRMAN: We hope that will not happen; but it may, of course.

Mr. MAYHEW: On the basis of change, you are admitting new evidence now. With further changes, you will have to admit further evidence.

Hon. Mr. MACKENZIE: It will be hoped that there will be substantial agreement in this committee upon the fundamental purpose of these proposals before the provincial conference takes place. We might be able to report to the house after that. Then there would be no further proposals submitted in regard to this measure.

The CHAIRMAN: You have heard the motion. All in favour? Opposed?

Motion agreed to.

Mr. HATFIELD: It would look as though we shall need very many more hospitals in the country after this bill comes into effect and an increase in present hospital facilities. Is there any provision for assistance to the municipalities or the provinces in regard to more hospital facilities?

Dr. HEAGERTY: That is just a debatable point. There are some people who are under the impression that we will need a very great many more hospitals because there will be a lag of old chronic conditions to be taken care of. But the case of those old chronic conditions can be controlled by regulations so far as hospitalization is concerned. I am told that at the present time in New Zealand there are queues outside the doctors' office. That should not happen here if we regulate appointments in doctors' offices, requiring that consultation shall be by appointment. There is no difficulty about that. It is only a question of administration. It would not be possible for us to make any provision in this bill for increased hospitalization, as hospitalization comes under the jurisdiction of the provinces. No attempt has been made in this draft bill to give provincial commissions authority to build new hospitals. If additional hospitals are required, the commission may make application to the provincial authorities who have jurisdiction in respect of hospitals. The commission will have no authority in that respect whatsoever. The commission may make application to the provincial authorities for additional hospital space when required.

Mr. HATFIELD: Will there be any assistance granted to the provincial authorities?

Dr. HEAGERTY: Not under this bill.

Mr. HOWDEN: But the bill does imply that hospitals will be supplied in areas that are without hospital accommodation at the present time, does it not?

Dr. HEAGERTY: That is a matter for consideration by the provinces and the provincial commissions. We have not attempted to solve all of the minute problems associated with the provision of benefits. The commissions in the provinces will have to consider that problem.

Mr. HATFIELD: Is there not a great shortage of hospital facilities in the dominion?

Dr. HEAGERTY: The trouble at the present time is that there are not enough doctors and therefore relatively there are too many hospitals. Some of the hospitals have no staff and are therefore closed.

Mr. KINLEY: Mr. Chairman, the financial formula seems to be quite broad. It seems to me that the financial committee which presented this report should come before this committee, give us the reasons for their conclusions and other information so that we can intelligently understand it.

Hon. Mr. MACKENZIE: I quite agree with you; and they will be available at the next meeting, whenever the committee decides to sit.

Mr. BRUCE: I wonder if the chairman would be able to indicate when we shall meet again, so that we make our arrangements accordingly.

The CHAIRMAN: I am sure that every member of the committee would like to have some time to read over carefully, this bill and its provisions. I thought if we met again next Tuesday, it would perhaps be soon enough. Would that be satisfactory?

Mr. BRUCE: Yes.

Mr. VENIOT: I should like to have one point clarified. The minister said that the contribution by persons over sixteen years of age would be \$12 a year. Would that be paid by all the citizens of Canada or only by persons on a certain income level?

Hon. Mr. MACKENZIE: By all citizens of Canada who can afford to pay; with respect to those who cannot afford to pay, the amount is abated by the provinces.

Mr. WOOD: Would old age pensioners come under that category?

Hon. Mr. MACKENZIE: No. It is available to them, of course.

Mr. KINLEY: One thing which is a surprise to me is that the earnings of such a large number of people of this country are less than \$900.

Hon. Mr. MACKENZIE: \$950.

Mr. KINLEY: It is not true today. We may be abnormal now, but I do not think we will ever go back, in this country, to the level of \$950.

Hon. Mr. MACKENZIE: That was the 1941 census. I would not think it would be quite as low as that again.

Mr. BREITHAUP: What ages were in that average of \$950?

Hon. Mr. MACKENZIE: The committee will be able to tell you that when they meet next time.

Mr. LECLERC: I understand Dr. Heagerty has said that there is a shortage of doctors at the present time. Suppose that everybody, after paying his \$12 a year, had the right to call a doctor at any time of the day or night. I think that would be quite a burden on the doctors.

Dr. HEAGERTY: I think that probably will be the case in the beginning. Many people will want to make sure that the benefits are available and they may call the doctor unnecessarily; but after a time I think the whole thing will simmer down. It has not been the experience in New Zealand that there has been any increase in the demand for medical services or for hospitalization. The queues that I mentioned may be due to the fact that there is a shortage of doctors at the present time.

Hon. Mr. MACKENZIE: They are overseas.

Dr. HEAGERTY: Yes.

Mr. JOHNSTON: Would you not think that, if this plan of health insurance works out, there should be less requirement for doctors' services than before; and that, if there is more requirement, it would indicate a definite failure of the insurance plan?

Hon. Mr. MACKENZIE: Lots of people who need a doctor do not get one today.

Mr. MAYBANK: The doctor's wife can always say he is not in.

Mr. MACINNIS: Mr. Chairman, could we have the information that was put on record today available before we meet again?

The CHAIRMAN: Yes. We will have it tomorrow or the next day. We shall meet either next Tuesday or Wednesday, which will be decided after I have conferred with the chairman of the reconstruction committee. We try to avoid clashes of committees. You will receive ample notice. I would ask that members of the finance committee who were here to-day be present at the next meeting of the committee, please.

The committee adjourned at 12.25 p.m. to meet again at the call of the chair.

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Canada - Social Security, Spec. Com.
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SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 2

THURSDAY, MARCH 9, 1944

WITNESSES:

Hon. Ian Mackenzie, Minister of Pensions and National Health, Ottawa
Dr. J. J. Heagerty, Director of Public Health Services, Department of
Pensions and National Health, Ottawa
Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of
Statistics; and
Mr. R. B. Bryce, Financial Investigator, Department of Finance

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



MINUTES OF PROCEEDINGS

THURSDAY, March 9, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the chairman, presided.

The following members were present: Messrs. Adamson, Breithaupt, Bruce, Casselman (Mrs.), Coté, Donnelly, Gershaw, Gregory, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, McIvor, Shaw, Slaght, Veniot, Wood and Wright—27.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. E. Howes, Research Staff, Bank of Canada;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission; and

Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of Statistics.

Hon. Mr. Mackenzie read to the committee the report of the Committee on Health Insurance Finance *re* Public Health Grants in the First Schedule of the Dominion Health Insurance Bill.

Dr. J. J. Heagerty, Mr. J. T. Marshall and Mr. R. B. Bryce were called, examined and retired.

On motion of Mr. Kinley the committee adjourned at 1.00 o'clock, p.m., to meet again at the call of the chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

March 9th, 1944.

The Special Committee on Social Security met this day at 11:00 o'clock a.m. The Chairman, the Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Order, please. This morning the Minister (Hon. Mr. Mackenzie) will present the report of the committee on health insurance finance.

Hon. Mr. MACKENZIE: Mr. Chairman and members of the committee, I have a prepared report from the members of the Finance Committee who assisted the department in regard to some of the financial provisions of the bill; and I wish to emphasize that in making their report they have expressed their own views and not those of the department or the institutions which they represent. As a committee they represent the ablest men we have in the public service.

Mr. Chairman, with your permission, I will read this report. It is not very long. And then, afterwards, we will present to you the members of the committee; or, whatever procedure you may decide upon.

In accordance with the verbal request of Dr. J. J. Heagerty of February 9th, 1944, the committee has reviewed the several grants set forth in the first schedule to the Dominion Health Insurance Bill with a view to recommending the specific amounts to be set opposite each grant.

The committee understands that in the original proposals for health insurance in Canada, it was anticipated that the dominion might contribute, as its share towards the establishment of health insurance, a sum in the neighbourhood of \$20,000,000 together with an amount for specific public health grants of roughly \$7,000,000 to assist the provinces in extending their public health services.

In the "Tentative Costs of Health Insurance," as prepared by the subcommittee on health insurance costs, it was suggested that the dominion grant to health insurance might be calculated as a fractional part of the operational costs, namely:

one-ninth estimated at roughly \$25,000,000.

one-eighth estimated at roughly \$28,000,000.

one-sixth estimated at roughly \$37,000,000.

and two-ninths estimated at roughly \$50,000,000.

In the interim report of the Committee on Health insurance Finance presented to the Hon. Ian Mackenzie, Minister of Pensions and National Health, on the twenty-eighth day of December, 1943, the committee recommended a plan for financing of health insurance under which the dominion would assume roughly \$100,000,000 as its share of the cost, plus the task of collecting an additional amount of roughly \$50,000,000 on behalf of the provinces (the individual's portion of the health insurance contribution to be collected through the machinery of the income tax division).

In making its request Dr. Heagerty stated to the chairman of the committee that the deputy ministers of health of the provinces, in session as a Dominion Council of Health, had made direct representation for an increase in the amount of the public health grants, as follows:

Grant	Original Amount	Requested Amount
General Public Health	25 cents per capita	50 cents per capita
Tuberculosis (treatment)	$\frac{1}{6}$ provincial expenditure	$\frac{1}{4}$ provincial expenditure
Mental Diseases	$\frac{1}{6}$ provincial expenditure	$\frac{1}{4}$ provincial expenditure
Venereal Disease (control)	\$200,000	\$200,000
Professional Training	\$100,000	\$100,000
Investigational (Public Health)	\$ 50,000	\$ 50,000
Crippled Children	\$250,000*	\$250,000

* Amount recommended by Special Committee on Social Security of the House of Commons.

In view of the increase in the amount of the dominion's share of health insurance costs, the committee feels the provinces would not expect substantial increases in the original amounts suggested for the public health grants. It understands that originally these grants were to be used as an incentive to the provinces to adopt health insurance and were conditional upon provinces enacting approved health insurance legislation. The committee did not feel fully competent to deal with this matter without technical advice in the general public health field and in the specific fields of preventive medicine, in which assistance to the provinces is contemplated by the draft health insurance bill.

In arriving at the conclusions set forth in this report, the committee wishes to express its appreciation of the assistance of Dr. G. J. Wherrett, Secretary of the Canadian Tuberculosis Association, Lieut-Colonel D. H. Williams, Director of Venereal Disease Control, and Dr. B. T. McGhie, Deputy Minister of Health for Ontario.

The committee has taken into consideration the recommendations of the Rowell-Sirois Commission and the constitutional questions relating to public health, but also realizes that in certain phases of the public health program the problems have grown beyond the financial competence of some of the provinces as is instanced in the case of tuberculosis and venereal diseases, particularly if a vigorous campaign is to be made to stamp out these diseases. The committee feels that a determined attack on both these diseases is of national importance and understands it is the confirmed technical opinion that with sufficient funds made available to provide adequate preventive and treatment facilities, these diseases could be almost entirely wiped out in a relatively short period of time. Therefore, it is believed that the dominion would be justified in making relatively large grants towards the control of these diseases, if only on the grounds of long-range national economy.

On the other hand, the British North America Act has always reserved, as an exclusive power of provincial legislatures "the establishment, maintenance and management of hospitals, asylums, charities and eleemosynary institutions, in and for the provinces, other than marine hospitals". Yet even in the control of mental diseases, and in the financing of clinics and institutions for the mentally ill, there would appear to be sufficient justification for the dominion granting aid to the provinces, particularly in view of the effective advances in mental hygiene therapy for the prevention and control of mental diseases. The committee is informed that with the establishment of psychiatric clinics, the institutionalization of large numbers of mentally ill persons could be prevented. It seems that grants-in-aid to the provinces which would have the effect of providing for the extension of psychiatric clinics would be a sound socio-economic investment on the part of the dominion.

On these general grounds, therefore, the committee begs leave to make the following recommendations for the specific grants set forth in the first schedule to the Dominion Health Insurance Bill:

1. *General Public Health Grant*

The original proposal was for the distribution of a general public health grant to the provinces at the rate of twenty-five cents per capita, which, on the basis of population at the Census of 1941, would require an annual expenditure of \$2,872,428.

When this item was discussed with the provincial deputy ministers of health they were of the opinion that this amount should be increased to fifty cents per capita if the grant was to be sufficient to enable the provinces to extend health unit and other preventive services in line with the requirements. The committee has pointed out above that since the original proposals, it has suggested that the dominion's share to the health insurance proposals should be increased very substantially, and as the Health Insurance Bill proposes a co-ordination between the public health and health insurance services, it should be possible, through a co-ordination of administrative services for both purposes, to increase under the present plan the general public health services at relatively little extra cost. The committee, therefore, does not feel prepared to recommend any increase in the amount originally proposed, namely, twenty-five cents per capita.

2. *Tuberculosis (treatment) Grant*

The amount of the tuberculosis grant should be a total of one-quarter of the moneys expended by all provinces during the previous fiscal year for the free treatment of all persons suffering from tuberculosis, excluding capital expenditure, not to exceed \$2,000,000 annually, and to be distributed on the following basis:

- (a) 50 per cent to be distributed to the provinces on the basis of the per capita distribution of the population as enumerated at the last census; and
- (b) 50 per cent to be distributed according to the average number of deaths from tuberculosis in each province over the previous five years, as certified by the Dominion Statistician.

The committee feels that any grant-in-aid to the provinces in connection with tuberculosis control is a sound investment if it is such as to lead, over a period of years, to a substantial reduction in the incidence of the disease. It is also suggested that outlays for capital expenditure in this field should be considered as part of a national reconstruction program, and that the grant for tuberculosis under the proposed Health Insurance Bill should be used solely for treatment and prevention and not for capital expenditure.

The recommendation for distribution of 50 per cent of the total grant on the basis of the average number of deaths from tuberculosis is in line with a suggestion made by the Canadian Tuberculosis Association and is designed to offset a very apparent uneven distribution of the problem as between provinces. The fact that in the province of Quebec and the maritimes the tuberculosis problem is three times that of the other provinces, would appear to justify the claim for distribution of at least a part of the grant on the basis of provincial needs in combating the disease, and the committee is of the opinion that the suggested basis of distribution on the five year average number of deaths would be the fairest basis for distribution of the second part of the tuberculosis grant.

3. *Mental Disease (treatment) Grant*

The amount of the mental disease grant should be one-seventh of the moneys expended by all provinces during the previous fiscal year for the free treatment of all persons suffering from mental illness and for mental defectives, excluding capital expenditure, to be distributed on a per capita basis and not to exceed \$2,500,000 annually.

According to figures supplied to the committee, the total expenditure for the year 1942 for all provinces for mental diseases was in the neighbourhood of \$19,200,000. The original estimates of the subcommittee on health insurance costs placed the total amount of the grant, on the basis of one-ninth of the total provincial expenditure, at \$2,171,485. This was based on a total expenditure of \$19,543,364 for the year 1941. The committee did not feel able with the evidence before it to make any recommendations for increasing the amount of the grant for the free treatment of mental diseases to one-quarter of the provincial expenditures, but suggests that this item might be left for further discussion at a Dominion-Provincial Conference, and that if the grant is to be increased, the provinces should be required to demonstrate the need for extending services in this field and also the effect thereof upon the national well-being through the reduction in the incidence of mental diseases.

It is realized that the care and treatment of the mentally ill has from Confederation been the special and direct responsibility of the provinces. On the other hand, in view of the evidence presented to the Special Committee on Social Security demonstrating the achievements and potentialities of psychiatric clinics and also showing that "the amount forfeited if all patients were treated free of charge would be much more than one-ninth of the gross cost of care for all patients", there would, we believe, be ample justification for the dominion making some considerable grant to the provinces to assist them in extending the psychiatric services and in providing free treatment facilities which would be necessary as a policy consistent with general health insurance.

It is also suggested that outlays for capital expenditure in this field should be considered as a part of a national reconstruction program, and that the grant for mental diseases under the proposed health insurance bill should be used solely for treatment and prevention and not for capital expenditure.

4. *Venereal Disease (control) Grant*

The committee believes, following its discussions with the Director of Venereal Disease Control, Department of Pensions and National Health, that there is a real opportunity at the present time to take advantage of the public's consciousness of the problem of venereal disease, which has been made evident by the war, to inaugurate a determined attack on this problem with the object of eradicating venereal disease within the next decade. Experience in the Scandinavian countries and Russia indicates that a determined attack of this nature offers very real chances of success in reducing the incidence of the disease quite materially.

The amount of the venereal disease grant should be \$1,000,000 a year for a period of ten years, to be divided annually as follows:

- (a) 50 per cent distributed on the basis of population as shown in 1941 census; and
- (b) 50 per cent distributed according to the number of new cases of venereal disease reported in the previous calendar year, as certified by the dominion statistician.

This grant to be made on condition that each province matches its share of the grant by an equal amount.

In respect of capital expenditures for this particular purpose, it is suggested that provinces be permitted to compound these in the first part of the grant over the full ten years.

It was evident to the committee, from expert advice received, that the original amount of \$200,000 (which was apparently based on an estimate made in 1919) would be totally inadequate to meet the immediate pressing need if real and permanent improvement is to be effected. We feel that the time has come to press a determined attack upon venereal diseases, and it was understood that a ten-year program (as in the United States) would be necessary and adequate to reduce the problem very materially.

Following this ten-year program it is believed that expenditure could be substantially reduced.

5. *Professional Training Grant*

The original amount suggested for distribution to the provinces to enable them to provide public health training for physicians, dentists, nurses, etc., was placed at \$100,000. The committee felt that while this amount does not appear to be sufficient to train the additional personnel which would be required to introduce health insurance and extend the public health services in all the provinces, it had in mind that such professional personnel returning from overseas might be afforded special post-graduate training under the National rehabilitation program; and were of the opinion that in such a comprehensive and all-embracing scheme of medical care as envisaged by the proposed bill, there would be considerable increase in the number of trained personnel required. The committee therefore recommends that the amount of this grant be left at \$100,000.

6. *Investigational Grant*

The committee would respectfully point out that as presently written in the draft health insurance bill under the column headed "Annual Amount of Grant" opposite the item "Investigational Grant" the words "not to exceed . . . dollars for any one investigation" fails to limit the annual expenditure which might be sought under this heading. Subsequently Dr. Heagerty made a statement to the effect that this item was originally meant "not to exceed a total of \$50,000 to the provinces, collectively". While the committee feels that such an amount might under ordinary circumstances be sufficient to meet the requirements, on the other hand, in cases of emergency several hundred thousand dollars might be required for the investigation and suppression of one disease in epidemic proportions. After due consideration of a memorandum from Dr. Heagerty dated February 28, 1944, outlining in detail the requirements under this particular grant, the committee is in accord with the suggestion that the title of this grant should be changed to "Public Health Research" and the item in schedule one of the Dominion Health Insurance Bill reworded as follows:—

Public Health Research.	To assist the province in conducting research in the field of public health.	The province to satisfy the Governor in Council of the need for the grant and its effective employment.	Not to exceed \$50,000 in any one year.
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The committee is of the opinion that the expenditure of public money for medical and public health research is economically sound, and that a few thousand dollars spent in this manner may be the means of saving many lives and preventing untold human suffering; and understands that ample provision is contained under sections 9 (1) (b) and 9 (2) (d) of the draft dominion health insurance bill and section 9 (2) of an Act respecting the Department of Pensions and National Health, which would enable the Governor General to provide emergency funds in the event of epidemics.

7. Crippled Children

See recommendations of the Special Committee on Social Security of the House of Commons.

SUMMARY

In respect of the tuberculosis, mental and venereal diseases grants, it is suggested that they should be conditional on their being taken up by the provinces within five years of their being approved by the Governor in Council.

Respectfully submitted, for consideration of the Hon. Ian Mackenzie, Minister of Pensions and National Health, this third day of March, A.D. 1944.

R. B. BRYCE, *Financial Investigator,*
Department of Finance.

H. C. HOGARTH,
Assistant Chief Inspector of Income Tax.

J. E. HOWES,
Research Staff, Bank of Canada.

E. STANGROOM, *Chief Insurance Officer,*
Unemployment Insurance Commission.

J. T. MARSHALL (*Chairman*),
Dominion Bureau of Statistics.

Mr. Chairman, I can only add that this report has not been before the government as such at all, it is sent by the department to this committee for its study and consideration.

The CHAIRMAN: Thank you, Mr. Mackenzie. Would Dr. Heagerty present the members of the committee?

Dr. HEAGERTY: I would like to introduce to you Mr. Marshall, who is the Chief of the Vital Statistics Division of the Bureau of Statistics. Mr. Marshall is a member of the Advisory Committee on Health Insurance and as he is chairman of the Finance Committee, I will ask him to introduce the other members of that committee.

Mr. MARSHALL: Thank you, Dr. Heagerty. Mr. Chairman, I would like to introduce first Mr. J. E. Howes; then Mr. H. C. Hogarth; Mr. E. Stangroom; and Mr. R. B. Bryce.

The CHAIRMAN: Are there any questions arising out of the report? Dr. McCann, you had a question?

Mr. McCANN: The question that I interjected had to do with the grant for tuberculosis. I see it is made on the basis of the death rate. Another way that it could be made would be to take it on a more positive line with reference to the number of cases discharged as cured from sanatoria in each area.

Dr. HEAGERTY: As Dr. McCann knows we do not refer to cases that are discharged from the hospital as cured cases. You know, Dr. McCann, as well as I do, that they are referred to as arrested cases. Moreover, the number of arrested or cured cases is no indication of the actual number of cases of tuberculosis in the community. The only actual index we have of the number of cases in the community is the number of deaths. It is generally agreed that there are approximately six cases of tuberculosis to each death. We are sure in so far as deaths are concerned we are on fairly safe ground, inasmuch as these deaths are an indication of the actual number of cases in the community, and cases potentially requiring treatment. Does that answer your question?

Mr. McCANN: Partly; how are the deaths recorded, on the certificate of the attending physician?

Dr. HEAGERTY: Yes, they are reported on the certificate of the attending physician. They are collected by the vital statistics division of the Bureau of Statistics so that the dominion is informed in regard to the actual number of deaths that takes place each year.

Mr. LOCKHART: Can Dr. Heagerty say whether this conclusion has been arrived at after conferences with the provinces or with the deputy ministers of the different provinces or is it just a conclusion arrived at in Ottawa?

Dr. HEAGERTY: It is an accepted principle, and arrived at after discussion with the provinces. You will remember that Dr. Wherrett, secretary of the Canadian Tuberculosis Association, appeared before this committee and expressed his views in regard to the prevalence of tuberculosis in the community and the measures that should be adopted for prevention and control.

Mr. LOCKHART: An accepted principle by whom, may I ask?

Dr. HEAGERTY: By public health officers. It has not been accepted as yet by this committee. It is now placed before this committee for consideration.

Mr. McCANN: In the original draft with reference to tuberculosis was it intended to make grants to the provinces for the purpose of capital expenditure extending housing facilities, and the like of that?

Dr. HEAGERTY: That was the original intention, but the grant is worded in such a way in the present bill that there is no restriction imposed. I believe it was thought by the committee on finance that if a definite amount were specified we might be restricted to that amount whereas under the suggested new reconstruction department more money might be available. I may perhaps refer that question to Mr. Marshall for confirmation. Is that the case Mr. Marshall?

Mr. MARSHALL: Yes, that is correct.

Mr. McCANN: This grant to all provinces according to this draft will not be in excess of \$2,000,000?

Dr. HEAGERTY: A year.

Mr. McCANN: Take the province of Ontario; they will get very little of that. According to my recollection their expenditure for tuberculosis last year was in the neighbourhood of \$7,000,000.

Dr. HEAGERTY: As Mr. Mackenzie pointed out to you the distribution is proposed to be made on the basis of 50 per cent per capita and 50 per cent on the number of deaths. There are certain provinces in which the death rate is much higher than in other provinces, and that is the case in spite of the fact that some of the provinces in which the death rate is high are expending almost as much money as Ontario at the present time. The problem is not as great in Ontario because it has been attacked vigorously over a period of years. In Quebec and in the maritime provinces the problem is very much greater. Therefore Quebec and the maritimes should be entitled to a larger amount of the grant. Hence the reason for suggesting that 50 per cent of the grant should be based on the death rate.

Mr. McCANN: What I am trying to point out is this; take a province like Ontario that has approximately one-third of the population of Canada. We are expending at the present time \$6,000,000 to \$8,000,000 on tuberculosis and their share of it would be probably \$600,000 or \$700,000. That is only a drop in the bucket compared to what they are already spending. This federal assistance is not going to be of sufficient value, in my judgment, to promote the extension of the facilities that are already in operation with reference to tuberculosis in the province.

Dr. HEAGERTY: You asked me at the outset whether the subject had been discussed with the provincial authorities. I had in mind the ministers of health or premiers of the provinces. It has not been discussed with them but has been discussed with the dominion council of health which, as I have pointed out on a former occasion, has among its members the deputy minister of health of each of the provinces. It was their recommendation that the amounts specified should be provided for the provinces under the conditions that have been indicated to you by Mr. Mackenzie.

Mr. DONNELLY: Did I understand you to say that no consideration was given at all to the financial position of the provinces, that it was distributed entirely on the number of tubercular cases and deaths?

Dr. HEAGERTY: Consideration was given to the problem from the standpoint of the number of cases, the number of deaths, and also the amount of money expended. All of these factors were taken into consideration when the subject was discussed before the Dominion Council of Health.

Mr. KINLEY: I presume the primary object is to cure the disease, and that you are going to attack it wherever you find it?

Dr. HEAGERTY: That is the primary object but apart from that it has been considered practically impossible under health insurance to provide people suffering from tuberculosis and mental disease with adequate and prolonged treatment in general hospitals, and it is considered therefore that there should be provided for them separate and distinct treatment in institutions devoted exclusively to their particular care and treatment.

Mr. McIVOR: Have you enough accommodation to take care of cases that are reported?

Dr. HEAGERTY: That is doubtful. I cannot answer that question exactly but it is known that in some of the eastern provinces there is not sufficient accommodation at the present time.

Mr. LOCKHART: Mr. Chairman, would this not be penalizing a province which may have been attacking the problem in a worthwhile way? I rather agree with Dr. McCann's suggestion that this problem having been attacked very vigorously in the province of Ontario it would look as if they were more or less penalized. Would that not be the result of this proposal?

Dr. HEAGERTY: Tuberculosis is a national problem and has been attacked by each of the provinces vigorously in so far as their funds have permitted. The first campaign against tuberculosis was begun in the year 1900 in the city of Montreal. Since that time the death rate has been reduced 75 per cent. In Ontario it has been reduced 40 per cent in the past ten years. There is no doubt that in Ontario funds are more readily available than in some of the other provinces, and the idea is to assist the other provinces in conducting as energetic a campaign as Ontario in respect to the attack upon this problem.

Mr. WOOD: I should like to interject a suggestion here. Ontario has spent a great deal of money on the eradication of tuberculosis and they have done a good job. We found that there were many sanatoria that had worked themselves out of positions. That happened right in the city of Brantford. As the representative of Brant, and taking an interest in our citizens up there, we have 5,000 Indians located in that centre who have been pretty well cleaned up of tuberculosis, but we found there was a great deal of infection coming from the Indians because of their being located in that section. The Department of Indian Affairs a few years ago—I had something to do with bringing it about—endeavoured to harness up a lot of that machinery. They had worked themselves out of a job in consequence of the aggressive plan of attack in the province of Ontario. The Indian Department under the federal government has been using a lot of those facilities, and

that additional expenditure has gone in with the expenditure of the province of Ontario. I just thought I would bring this to your attention so that we could get a proper balance in regard to the credit due each province in their contribution to eradicate this national disease.

Mr. McCANN: The estimated amount with reference to the whole scheme was given the other day as \$250,000,000. \$100,000,000 of that was to come from fees and \$50,000,000 from the income tax. That left about \$100,000,000 to be provided by the dominion. How much difference will these changes make in the contributions which the dominion will make? Will they lower this \$100,000,000, and is it the policy of the government to bring the whole aggregate cost of the scheme down somewhat? Is that the reason why there has been a revision in some of these financial arrangements?

Dr. HEAGERTY: No, the amounts mentioned this morning by Mr. Mackenzie are in addition to the \$100,000,000 proposed contribution of the dominion. These amounts have been revised upward. These are for public health. They are in addition to the amounts specified but with further reference to the previous discussion, you are fully aware of the fact that the provinces will not decrease their expenditures. These grants will stimulate them, if anything, to increase the amounts expended by them and will probably release provincial money for the purpose of prevention.

Mrs. CASSELMAN: That is, these amounts will be expended in addition to what the provinces are already expending?

Mr. McCANN: Quite.

Mrs. CASSELMAN: Alberta is expending quite an amount along that line and is right in the top rank of those who are fighting tuberculosis.

Mr. MACINNIS: I was going to say that from my understanding of what Dr. McCann said his objection would not be to the allocation of the amounts as between provinces but to the inadequacy of the amount itself. I think you said Ontario would get \$600,000 of this amount, and that is only an approximate figure. The amount that would be left for the other provinces would be only \$1,400,000 which would leave their amount very small, indeed. In the case of the maritime provinces where the need is great and the population not so large that amount would again be reduced. Therefore, I think we should give consideration to increasing this amount.

Mr. LECLERC: According to what my friend, Dr. McCann, said the Ontario people seem to think that they are going to be penalized because they will not get as large a portion of the grant as the other provinces.

Mr. McCANN: This is not my idea. The idea is that when you are taking this step these amounts as suggested are not adequate to meet the problem.

Mrs. CASSELMAN: Not meet the whole problem; the province has already expended a lot.

Mr. McCANN: I understand that.

Mr. LECLERC: Ontario is spending more money to-day than the other provinces. It may be due to the fact that the Ontario people are more intelligent. However, I think there is one thing we can agree on, and that is the fact that Ontario is much more wealthy than the other provinces. Ontario has the largest number of industries in this country. That is where the provincial government are getting their revenue. The province of Ontario has been able to spend more money due to the revenue it receives. The eastern provinces are not so fortunate in that respect and, as the deputy minister said, I think tuberculosis is a national problem and it should be regarded in that light.

Hon. Mr. MACKENZIE: May I just make a suggestion? I think we should rather deprecate a comparison as between one province and another. We should look at it as a national problem, the main object being the eradication of tuberculosis. When Ontario is doing so much we absolutely must commend what they are doing, and Saskatchewan particularly. I think Saskatchewan leads the whole dominion. All the provinces are doing wonderful work, but this is for the first time national recognition of the campaign in co-operation with all the provinces over a number of years to eradicate tuberculosis altogether in Canada, and personally I do not like to see a comparison as between the provinces. It is not the spirit of the thing. The spirit of the thing is a national grant where it can be best used to stamp it out wherever it exists—I do not care whether it is Quebec or British Columbia or the maritimes—stamp it out the best way we can. That is the idea behind it.

Mr. McCANN: Yes, but the question boils down to this, whether this grant is going to be sufficient to stimulate any province to make additional capital expenditure that will be necessary to carry out the program.

Hon. Mr. MACKENZIE: Of course, fundamentally it is a provincial responsibility. This is the first time we have ever tried to do anything like this so that I think we should make a good beginning if we can. I think it would be very helpful.

Mr. MACINNIS: It would be helpful to have the figures as to the amount allocated for each province, the death rate in each province and the population. Then we would know exactly how much each province was likely to get over the next few years.

Mr. KINLEY: I think if Dr. Heagerty would show the picture that this is only supplementary it would look better.

Dr. HEAGERTY: The total expenditure for treatment in Canada is only just over \$8,000,000, and the proposed grant of \$2,000,000 provides one-quarter of the entire expenditure for treatment which is obviously a fairly generous amount. I have the breakdown by provinces here if you care to have it.

Mr. MACINNIS: I think that would be desirable.

Dr. HEAGERTY: Do you want the breakdown?

Mr. MACINNIS: Yes.

Dr. HEAGERTY: The total for Canada is \$1,999,604.96. It has not been possible to break it down to an exact \$2,000,000. The average number of deaths for the whole of Canada during the period 1937 to 1941 was 6,127. Prince Edward Island—number of deaths—was 67, proposed grant \$19,204.29.

Hon. Mr. BRUCE: For the whole of Canada?

Dr. HEAGERTY: Yes, number of deaths in Canada including Indians, was 6,127. In Nova Scotia deaths were 430 and the amount of grant \$120,463.85; New Brunswick, deaths, 325; grant \$92,837.79; Quebec, number of deaths, 2,650, and the total amount of grant \$722,385.53; Ontario, number of deaths, 1,150, and the proposed amount of grant \$517,219.79; Manitoba, deaths, 368 and the amount of grant \$123,549.74; Saskatchewan, number of deaths 266, and the total grant \$121,365.70. Alberta, deaths 311; the total grant, \$12,025.64. British Columbia, 560. The death rate among Indians is very high in British Columbia. The total grant, \$162,552.63. So that the grant parallels the number of deaths. Before concluding, I may say that the death rate among Indians in Canada is at least ten times as great as among the whites. We have made provision in this bill, page 39, section 46, for the provincial governments if they so wish, to enter into an arrangement with the Indian Affairs Branch of the Department of Mines and Resources to include Indians in health insurance. If you will refer to section 46, you will find the reference.

Mr. SHAW: May I ask if that would apply to non-treaty Indians as well as to treaty Indians?

Dr. HEAGERTY: To all Indians; all those who are under the Indian Act and I believe that act includes all Indians.

Mr. LECLERC: May I ask what province has the greatest number of Indians?

Dr. HEAGERTY: Ontario and British Columbia.

Mr. SHAW: While we are dealing with this matter of Indians, may I point out that there was a reason for my asking about non-treaty Indians. In the Rocky Mountain House and Whitecourt districts of Alberta we have about 300 to 400 non-treaty Cree and Chipewyan Indians. I am told by medical men, particularly the doctor at Rocky Mountain House who examined the young men who were called to report for military service, that venereal diseases and tuberculosis are just ravaging that tribe. They go out during the harvest season and work among the whites. Evidently they are not the responsibility of the dominion government or so the correspondence I have had with the Minister of Mines and Resources would indicate. They are not the provincial responsibility. But they are an absolute menace to the health of the white population. I am particularly concerned about that situation. I should like to know if anything is to be done in connection with that band of Indians.

Dr. HEAGERTY: That I cannot answer. We have had discussions with the Dominion authorities in regard to the provision of medical care for Indians, and those discussions, I assume would refer to all Indians who come under the jurisdiction of the Dominion. Section 46 refers to "reciprocal arrangements on questions relating to health insurance with the government of Canada on questions relating to health insurance for Indians as defined in the Indian Act, chapter 98 of the Revised Statutes of Canada, 1927." I cannot tell you whether the Indians referred to by you come within that definition.

Mr. SHAW: I should like to point out that the situation is so serious that not one Indian was passed for military service, and I was told by a nurse with whom I spoke that the infant mortality rate is terrific among those people. I should like to ask the minister if, at some future time, he might be able to give me some information about that particular band.

Hon. Mr. MACKENZIE: I shall be glad to look into that. I will read the observations of my honourable friend in the record, and will be glad to get in touch with him.

Mr. JOHNSTON: The minister indicated that this is to be a national program for Canada. Surely we are not going to leave out one section, and not include it with the rest of the country. That would seem to me to be absurd.

Mr. KINLEY: Do you think the condition in the maritimes is wholly owing to the lack of medical treatment or has exposure, the mode of living and climate anything to do with the situation?

Dr. HEAGERTY: Tuberculosis is a disease of poverty, and in areas in which wages are low and families large, housing conditions are usually bad, nutrition is deficient, and the incidence of tuberculosis higher than in other parts of Canada.

Mr. KINLEY: How do we compare with Newfoundland?

Dr. HEAGERTY: I am unable to answer that question.

Mr. MACINNIS: You should not compare them with Newfoundland.

Mr. KINLEY: I just wanted to know.

Mr. WRIGHT: In this brief on page 4, it states: "It is also suggested that outlays for capital expenditure in this field should be considered as part of a national reconstruction program." Does that mean that the dominion government intend to spend money for sanatoria in the provinces over and above this amount which is stipulated here?

Hon. Mr. MACKENZIE: That is only the recommendation of the committee. It has never been before the government at all. It is purely for discussion by this committee. What the ultimate program may be, I am not in a position at the moment to state.

Mr. WRIGHT: I think that is an important point.

Hon. Mr. MACKENZIE: Yes.

Mr. WRIGHT: Because if it is supplemented by buildings, it means a good deal. If it is not, then it is not sufficient.

Mr. GERSHAW: In connection with section 5 on page 7, the professional training grant, there is a question that occurs to my mind. Of course, every one agrees that there will have to be a large number of physicians, dentists, nurses, etc. trained. It speaks of the national rehabilitation program. As I understand it, that would cover the tuition fee and probably an amount per week for each student. But those tuition fees do not cover the cost of instruction. It seems to me there would be a tremendously increased amount required by the institutions that trained these particular classes. Then I have one other question. The doctors and dentists will be expected to provide some of their own material, yet under this scheme, pretty complete medical care is proposed. Where is it provided for such things as x-ray apparatus or electrocardiograph apparatus and those things which no one doctor would provide for himself? Is it proposed that those who return from service in the army will be helped? Will some arrangement be made by which they will be established in the various areas where they are required, will this expensive equipment be provided, and if so, under what circumstances?

Dr. HEAGERTY: This grant applies only to public health and provides for the training of doctors, dentists, nurses and others who intend to enter the public health field. No provision has been made for education in the field of medicine.

Hon. Mr. MACKENZIE: Not under this.

Dr. HEAGERTY: Not under this section or under the Bill. We have not gone into that question. The medical profession is most anxious that some provision should be made to educate young men as doctors. The only provision, so far as I can say, that has been recommended by the medical profession is the provision of bursaries for brilliant students, but that would not give us a sufficient number of young medical men to carry out the provisions of the health insurance bill. We will need more physicians. There are some people who believe that the universities should now be brought into the field of general education, and that young men with high qualifications should be provided with medical education in the universities free of charge, in the interests of the people of Canada and of Canada itself. This grant does not refer to that measure.

Mr. McCANN: This grant, in my judgment, is not nearly sufficient. The majority of men who are engaged in public health work, after graduation, take a course either at the Toronto University School of Hygiene or at McGill University. It would cost each man taking that course for a year at least \$2,000. At the present time in Canada, particularly in Ontario, most of that cost is met by grants from institutions such as the Rockefeller Institution and different large funds which have been set with reference to the education of men for public health work. The statement was made here last year that, in order to put health insurance into effect, or the preventive features of it, it would require at least four hundred more men to be trained in public health work. At the rate of \$2,000 a year, leaving out nurses and dentists and sanitary engineers, that would only educate fifty men a year with this \$100,000. If that is the case—and I think that statement is relatively accurate at least—it is

going to mean that it will take a period of eight or ten years before you will have sufficient well-trained personnel in public health work and preventive medicine to meet anything like the needs that we have at the present time; and that is without making any provision for a possible large influx of new population into this country within ten years after the war is over.

Mr. KINLEY: Incidentally, the morning press had an account of a discussion in the provincial legislature of Prince Edward Island to the effect that they were bringing doctors in under some scheme—and it seems a very good thing. I presume that you know the details of it, Dr. Heagerty?

Dr. HEAGERTY: I read the statement in the morning papers. Apparently what they are recommending is the adoption of the scheme that is now in effect in Alberta and in Saskatchewan in providing municipal doctors by taxation and by contribution from the provinces. In the article of this morning reference was made to assistance from the federal government, but I am not familiar with that.

Hon. Mr. MACKENZIE: May I explain the situation to Mr. Kinley. What has been considered by the medical procurement and assignment committee, which is largely composed of the doctors of the defence services and members of the Canadian Medical Association and others, has been some scheme similar to the Australian scheme whereby you would get doctors in, they assuming the rank of major on joining the forces, and having them assigned to a certain district, getting the pay and allowances of a major's rank, thus fulfilling a long felt want of places in Saskatchewan that some of my friends know about, and others. That has not been adopted, as far as I know, but there has been discussion along this line. I understand that is what Dr. MacMillan referred to in Prince Edward Island. They have been considering for some time various ways of alleviating the situation in regard to medical services in various parts of Canada.

Mr. JOHNSTON: Would that all be worked on a salary basis?

Hon. Mr. MACKENZIE: In Australia the plan is this. They gave the doctor the rank of major, and the pay and allowances of a major's rank, and he is assigned to a certain locality. He is entitled to charge fees. The province would reimburse the amount of his pay and allowances, and anything he received in the way of fees would go against that to the provinces.

Mr. JOHNSTON: That is only a wartime measure?

Hon. Mr. MACKENZIE: Yes.

Mr. KINLEY: National Defence provides the man and the province would pay the cost, or that part which is not taken up by the fees?

Hon. Mr. MACKENZIE: Yes. That is the suggestion.

Mr. KINLEY: No doubt they put in about \$5,000.

Hon. Mr. MACKENZIE: I do not know how far it has gone. I think Dr. MacMillan has been in touch with them down in Prince Edward Island. When I read the press this morning I gathered he was referring to that.

Hon. Mr. BRUCE: I have the item here. It was suggested that this was a federal plan in the Canadian Press report. From what the minister has just said, I take it that it is not a federal plan.

Hon. Mr. MACKENZIE: It is the result of the discussion of the medical procurement and assignment committee which is a federal committee, in co-operation with the Canadian Medical Association and others throughout Canada.

Hon. Mr. BRUCE: I understood you to say a moment ago that this was just a war measure. I was under the impression that it was intended to relieve rural communities of the difficulty from which they suffer, that of not having a doctor at all.

Hon. Mr. MACKENZIE: Yes.

Hon. Mr. BRUCE: And therefore it would mean a plan that would take care of all those communities for the future in perpetuity.

Hon. Mr. MACKENZIE: It might do. That really does not come in my department. I am only supplying information to the committee in regard to the question asked. Generally speaking, I think that has been the nature of the discussion in regard to the situation.

Mr. JOHNSTON: May I ask Dr. Heagerty a question. On page 7 reference is made to a professional training grant of \$100,000. It says here, "To enable them to provide public health training for physicians, dentists, nurses, etc." What does "etc" means? Does it mean that there will be others who will share in this contribution, such as chiropractors for instance, if they wish to take up health training? Would they come under this \$100,000 grant the same as doctors, dentists or nurses, or is it confined particularly to the medical profession?

Dr. HEAGERTY: It is not confined to the medical profession. The "etc." would include sanitary engineers who wish to become public health engineers and specialize in that particular field. It would also take in nurses. It would also provide training for men who might wish to become food inspectors and so on. But there is no intention of bringing chiropractors into the field of public health, as they are not engaged in the field of prevention. Public health means the prevention of disease, whereas the chiropractor confines his services to the treatment of disease.

Mr. McIVOR: Will this include training of doctors for special industries? We know that, in industrial work, there is special treatment for special diseases, which is perhaps not generally known.

Dr. HEAGERTY: That would be a matter for the provincial authorities to consider. To-day public health doctors are specializing in the prevention of industrial diseases; and if a province wished to train a man or a number of men in that particular field, there would be no objection to doing so.

Mr. LOCKHART: It would appear that several opinions have been expressed, and many of these opinions and quotations have emanated as the result of experience and practice in certain provinces. I am wondering to what extent the provinces have been brought together in connection with this matter? Has this health measure been discussed only by the national committee, and have the provinces not been brought in, in order that one great scheme could perhaps be put into effect?

Hon. Mr. MACKENZIE: There was one meeting held with the ministers of health of the various provinces, when the proposals were in a more or less general form.

Mr. LOCKHART: Long before this bill was presented?

Hon. Mr. MACKENZIE: Yes. Secondly there was a meeting of the Dominion Health Council when the program was more or less advanced, and there will be very soon a further meeting of the Dominion Health Council to discuss the present proposals.

Mr. LOCKHART: It will not change the whole set-up?

Hon. Mr. MACKENZIE: No.

Dr. HEAGERTY: Before the meeting of the provincial ministers of health referred to by the Hon. Mr. Mackenzie I drew up three draft Bills and submitted them to the Department of Justice. That department approved of one particular Bill. It was presented by me to the Dominion Health Council on a number of occasions, and the contents made known to the provincial ministers of health at the meeting referred to by the Hon. Mr. Mackenzie.

Hon. Mr. BRUCE: It seems to me that having regard to the point raised by Mr. Lockhart and the discussion that has been going on this morning, we would make more progress if a conference was held between the dominion and the provinces, such a conference as has been referred to on several occasions and is referred to on page 5 of the submission presented this morning:—

“The committee did not feel able with the evidence before it to make any recommendations for increasing the amount of the grant for the free treatment of mental diseases to one-quarter of the provincial expenditures, but suggests that this item might be left for further discussion at a dominion-provincial conference, . . .”

We know that a number of eminent and distinguished men representing the finance committee have been working on this subject for some time, and they have drawn up what they consider to be the proper proportion to be paid by the dominion to assist the provinces in carrying out the various features of this proposed bill; but as these are financial matters I take it there will have to be a conference between the dominion and the provinces before any finality can be reached. I raised this question a few days ago in the house when I referred to this bill as a draft bill, but as the minister has indicated to-day, and as he did on a former occasion, these were really proposals of the department—

Hon. Mr. MACKENZIE: The advisory committee.

Hon. Mr. BRUCE: Yes, the advisory committee. And it had not been before the government for consideration. If we are to make any real progress with health insurance, which I am sure is the desire of every member of this committee, I think that we should urge upon the government the desirability of calling together the prime ministers and other representatives of the provinces at an early date to confer with the dominion on the various financial aspects of this measure. Until that is done we cannot accomplish very much here. I do not say that our time is wasted. Of course it is not, because there are many valuable suggestions being made here; but after that is done, and when we know that an agreement has been reached between the provinces and the dominion respecting an adjustment of powers and the financial set-up, we could get on more speedily with this bill. I make that suggestion because I noticed in the press a little time ago that the premier of Ontario had written to the Prime Minister of Canada early in January asking that such a conference be held at the earliest possible date to discuss the basis upon which post-war planning could be carried into effect. This request was submitted to all the provinces and a later press report stated that there was general agreement by them. I therefore put forward through you, Mr. Chairman, to the minister, and through him to the government, the suggestion that we as a committee urge the government to call this conference at as early a date as possible.

Mr. MACINNIS: Mr. Chairman, I discussed that very point with Mr. Wright before we came into the committee room to-day, and I am glad Dr. Bruce has brought it up because I believe we should have a clear understanding on where we are at if we are going to proceed in this matter with a definite purpose. I say that particularly because, although I did not see the item in the press, I am given to understand that there was an item in the *Montreal Gazette* following our meeting of last week, saying it was not the intention to introduce a health insurance bill this year. I do not know whether anybody else saw it. We have before us a draft bill, which is not the usual procedure in matters of this kind, and I understand that the draft bill has not the approval of the cabinet, and consequently the cabinet is not taking any responsibility for the bill that is before us. So that we might discuss this draft bill and come to conclusions in regard to the various clauses and sections therein, and the only result would be that the cabinet might give them consideration when preparing another bill that would have to come before parliament and might possibly be referred to a

similar committee. So I think we should have a very clear understanding as to our purpose in sitting here at the present time, and what we are going to get out of it in definite, concrete health legislation during the present session. (Hear, hear.)

Mr. McCANN: I appreciate the desirability of having a dominion-provincial conference, but I cannot see the need for immediate haste in that regard, because after all there have been conferences of all kinds with the advisory committee which was representative of all the provinces and of all the elements in the country concerned in this measure. The Dominion Health Council, which consists of the deputy ministers of health of all the provinces, have met on many occasions and while perhaps they were not in a position to speak for the governments they represented, at least they did enter into the discussions, and I have no doubt they carried back to their respective ministers in each province a report as to the stage at which this proposal has arrived. Now, suppose the dominion government called a conference within the next couple of months, the ministers representing the various provinces would say: "Well, what are your proposals?" and our answer would be: "Our proposals at the present time are being studied, and when we have brought them to a stage where we can give you some concrete suggestions with reference to the health measure that purport to assist the provinces in putting into effect a scheme of health insurance, and which from the dominion point of view we desire to assist"; so it seems to me that such conference should be delayed until we have studied the matter from beginning to end and have framed a bill which will have within its four corners proposals which the dominion government have arrived at with reference to the matter.

Mr. LOCKHART: I do not desire to press my ideas in this connection, but I cannot agree with Dr. McCann. The very success of any health measure that might be developed by the advisory committee and by the minister, and that finally, perhaps, might result in a bill to be presented by the government is dependent to a great extent upon the co-operation of the provinces, since they are paying a large share of the cost. I cannot follow Dr. McCann in his argument. I feel that as every province is struggling along in its own individual way to solve this problem they should be brought in as quickly as possible to co-ordinate their efforts across the country to stamp out all the diseases suggested by this health insurance bill. I would therefore join with Dr. Bruce in urging that the minister would be well advised to take in all the authorities who must co-operate in order to make this bill a success.

Hon. Mr. MACKENZIE: Mr. Chairman, I am sorry this discussion has taken place. I desire to review very briefly the history of the proposals and what has taken place to date. Last year in the speech from the throne the government of the day indicated its intention to promote health insurance throughout Canada, and I submitted some proposals to the members of the committee over which you presided a year ago. Your committee approved of the principle of the insurance proposals presented to you at that time, and we were asked to get in touch with the provinces. As the result of a further analysis of the financial proposals of last year we sought the co-operation of various departments of the government and received the benefit of the advice of the finance committee, as the result of which, on the very first day we sat this year, we submitted radically different proposals to this committee. You have mentioned a dominion-provincial conference. The government has declared in the House of Commons its intention to hold such a conference. It is our intention to hold a conference of the Dominion Health Council to consider the health measures in these proposals. I would like to have the benefit of the advice of this committee before the dominion-provincial conference is held, because there is a great deal of work to be done. Last year you heard 117 witnesses from all over Canada. Was not that of benefit? The mere fact that doctors and nurses came

before your committee last year and presented views to you and to the country at large was the best example of the operation of the democratic principle I have witnessed in my parliamentary life. As members of the dominion parliament why should not we discuss these proposals now before the provinces are called in. Of course the provinces must be called in, because health measures are partly a provincial responsibility. We are passing an enabling federal bill to permit the provinces to pass on these proposals, but it is necessary to receive the constructive opinions that the representatives of any party in this committee may desire to present before that conference is possible, and it is not possible immediately. We know that. We are in touch with the provinces. There are three stages: First of all, to discuss with these eminent gentlemen on the finance committee the financial proposals and ascertain why they have reached these financial proposals. Second, we must discuss other clauses of the bill, whether you commend them or condemn them. Third, the department should have the benefit of the combined judgment of this committee so that when you, Mr. Chairman, move your report the government will be apprised of the feeling of this committee before we meet the provinces. This should not be a political measure. The last thing it should be is a measure by either the Liberal, Conservative, C.C.F. or Social Credit party; it should be a measure emanating from the combined wisdom of all parties. The provinces are very well treated in this measure. You will have expressions of opinion from the provinces very soon, and some will agree with the proposals, but we want them all to agree.

Mr. McCANN: They know every proposal in it now.

Hon. Mr. MACKENZIE: After we make our report they can criticize any of the clauses in this bill, and the attempt will be made to meet their wishes as far as possible in order to obtain the combined Canadian opinion, thereon, because you cannot have a real national health bill in Canada until you get the combined national opinion. Now, I ask you this: Do not let your sensitive appreciation of the immediate necessity of having the dominion-provincial conference endanger the progress of this measure. There is lots of work to do on this measure, and we can do it right here and then send our proposals into the conference where, in all probability, they will be changed again. I think that is the logical way to proceed. I have been working on this measure for three years now, and I have had lots of obstacles and hurdles to overcome as well as receiving lots of co-operation from some who ordinarily might be supposed to oppose the measure.

Mr. KINLEY: I have no doubt that in due course we shall have a conference with the provincial authorities. I think they are aware of what is going on now. They get our reports, and scientific gentlemen study them. But at the last meeting it was suggested that the formula for payments was somewhat involved, and that we should bring the finance committee here to explain it. Time is going on, and it seems to me we should get down to these explanations. This finance committee was brought here to explain to us how they worked out that formula to provide the money.

Hon. Mr. BRUCE: I am not at all in disagreement with much that the minister has said, but I do not know of any "politics" in this committee—

Hon. Mr. MACKENZIE: I did not suggest anything of the kind.

Hon. Mr. BRUCE: I am only here to contribute the little knowledge I may possess of medical matters in furtherance of a bill which I think will be in the interests of the people of Canada as a whole, but I have always been under the impression that the question of health was to a large extent under the jurisdiction of the provincial governments. That being so, does it seem reasonable and proper that we should sit here as a committee of the House of Commons to consider a bill for such a long time without giving the representatives of the provinces an opportunity of studying, together with the dominion, the financial

aspects of this bill which will bear very heavily on the provinces if they are going to carry out its provisions. I do not think there should be any delay, if we are to expedite the passage of this bill. I believe we are putting the cart before the horse. But if it is impossible to arrange such a dominion-provincial conference at the moment because of pressure of work on the dominion government then we shall have to proceed with further consideration of this bill.

The CHAIRMAN: According to my information, purely unofficial, the provinces know very definitely what we are doing, and while they are unofficially in agreement with the principle of these proposals, they have not discussed them officially as yet. There are two things we can do: we can suspend our discussions until after a dominion-provincial conference is held, which I think would be fatal, or we can proceed to discuss these proposals, because I feel that when the dominion-provincial conference, which has been assured, is held, the first thing they will ask is: "What are your proposals? Tell us what you want done. You have studied these measures and your finance committee has studied them. Dr. McCann says these grants are not adequate. Let us agree on what would be adequate. Let us agree on what proposals should be passed in the interests of Canada." I do not think that any member of this committee desires to play politics with human misery, and no suggestion of that kind has been made. If we proceed in an amicable way and agree on what we consider to be the best proposals for a national scheme of health, and put them before the dominion-provincial conference, we can take them back if they are opposed to them, and in that way we could make rapid progress.

Mr. JOHNSTON: Mr. Chairman, before you go too far with this matter I want to associate myself with Dr. Bruce, especially in regard to the financial aspects of it. It is true, as the chairman has pointed out, that we should not delay all our deliberations here until the provinces are called in; but after all, as Mr. MacInnis intimated a moment ago, this draft bill before us now has not even received the sanction of the government, and the government might be in disagreement with it, and all our discussions may have to be repeated. Coming back to the financial proposals, one of the biggest obstacles to the success of this insurance bill may be the financial aspect, and we are concerned with having proper health insurance in Canada. We do not want a financial situation to arise that is going to interfere with the progress of this bill. On page 4 of the report of the committee on health insurance finance it is estimated that the tuberculosis (treatment) grant would be approximately \$2 million. Let me refer to the paragraph following clause (b) on page 4:—

It is also suggested that outlays for capital expenditure in this field should be considered as part of a national reconstruction program, and that the grant for tuberculosis under the proposed health insurance bill should be used solely for treatment and prevention and not for capital expenditure.

Now, the finance committee that drew up these proposals is here, and I believe that that hits directly on the point Dr. Bruce mentioned a moment ago. As I understand it, the finance committee realized that the amount set aside for section 2, \$2 million, would not be sufficient if they had to take in capital expenditures, and therefore the committee, realizing the necessity of the expenditure of the money, is assuming that the provinces will not have sufficient money for this purpose, and that it will be carried on in a national reconstruction program, as suggested here. If you do not call the provinces together, but proceed on the assumption here that the capital expenditures will be carried in the national reconstruction program and that is not the final decision and the burden is thrown back on the provinces, and the provinces say: "We cannot finance this measure," then you are stuck. So I think it is necessary that you have a meeting with the provinces in order to ascertain their financial ability in

regard to carrying the capital expenditures, because otherwise this particular section is going to be thrown out and we shall have to go over the whole ground again. I submit it is necessary to investigate the financial aspect of this measure very carefully.

Mr. McCANN: This committee has recommended that the outlays for capital expenditure should be considered as part of the national reconstruction program.

Mr. JOHNSTON: Suppose it is not considered?

Mr. MACINNIS: Dealing with the minister's own activities in regard to health insurance measures for Canada, and also the activities of his department, I think a great deal of work has been done, but the minister did not answer my question. My question was: If this committee can finish its consideration of this draft bill in time, then immediately following a conference with the provinces will a health insurance bill be introduced in the House of Commons this session? If not, we have no objective to work to, and we are only fiddling away our time.

Hon. Mr. MACKENZIE: All I can say is that if this committee reports to the house I will present that report to the government immediately for decision.

Hon. Mr. BRUCE: How can there be a decision by the government before the conference?

Hon. Mr. MACKENZIE: The two would be combined then. They would have a conference before submitting it.

Mr. VENIOT: May I suggest one of the chief objectives of our study at the present time is to establish a plan which will give to the country uniformity of medical services from coast to coast. I think that is one of the chief objectives that the draft bill has in view. It also has in view the establishment of a framework of medical services which will constitute the minimum standard of medical services which the provinces should adopt in order to benefit by the proposals which the federal government makes. Now, there is nobody in Canada better qualified to make a complete study of the proposals included in this draft bill than the present committee, because it comprises men from every province in the dominion. I see that if we were to ask representatives of the provinces to make a study of health insurance plans it would be practically impossible for representatives of each province to sit day in and day out for a period of time such as we are doing, since we are attending the present session of the House of Commons and are in a position to devote the time required to the studies essential to the creation of what I called a moment ago the framework of a health plan which will permit each province to adapt to it the shingles, clapboard or other trimmings they may desire to put into such a plan, but I do not think we should let these objectives escape from our minds and that we should endeavour to form a framework or pattern around which each province can build as perfect a plan of health insurance as it may think meets its own needs. I think this committee must adopt a certain number of principles which we consider to be basic principles upon which to build a health insurance plan.

Mr. LOCKHART: I do not desire to impose my ideas on the committee at length, but we have before us a draft bill of March 1 and a draft bill of March 8, and I do not know the difference between them unless it be some slight change in phraseology.

Hon. Mr. MACKENZIE: A slight difference in the wording only.

Mr. LOCKHART: I want to commend the minister for his effort in preparing the draft bill, which is the nucleus of something for discussion. I likewise commend the finance committee, who have set forth the financial aspects. I think we are largely in agreement that in principle the proposal has been well developed, but we come back to the point I mentioned a little while ago, namely, that the

success of a health insurance measure is dependent upon the cooperation of the provinces, and I am wondering to what extent the provinces have been advised? Have they been furnished with these draft bills and with all the information developed in this committee, including the briefs presented here? If the provinces have been fully informed I am wondering to what extent they are in agreement? I feel, Mr. Chairman, that great work has been accomplished here. The draft bill is a basis upon which we can proceed, but when the provinces find out what their obligations are and what they have to do in the matter of financing they may say: "We just cannot carry the load, and you will have to find out how to furnish more assistance." I think a meeting of the minister and the finance committee and the others involved should be held. As far as I am personally concerned this committee and the minister can deal with the general scheme and develop something which the committee should approve of in principle, but at the same time we can talk here until doomsday, and if it goes back to the provinces and they point out certain obstacles and hurdles they have to surmount the finance committee and the minister and others can find ways and means of carrying out the ideas presented by the provinces, and from that time on the minister would be in a position to present a real, concise program to the House of Commons.

Mr. WOOD: It seems to me from the remarks made here today that the provinces appear to be regarded as foreign to the dominion. There is nothing unusual about this scheme that did not apply to the old age pension. When the old age pension came down the dominion initiated a program and produced a draft bill that was finally accepted by the provinces, although not all at once.

Mr. LOCKHART: The dominion paid 75 per cent.

Mr. WOOD: No, only 50 per cent; and furthermore the provinces only paid 25 per cent and the municipalities 25 per cent.

Mr. LOCKHART: Finally?

Mr. WOOD: No; at the outset.

Mr. LOCKHART: I am speaking of finality.

Mr. WOOD: I think that we should be guided more or less by what we have done in the past and the success that has been attained. I can quite understand that there may be certain provinces who are beginning to think they have not come into existence, but there have been men in Ontario and other provinces who have given consideration to this measure, and you have to have something for them to decide upon. Dr. Bruce said we were putting the cart before the horse. I submit that we have to have some concrete measure for them to pass their judgment upon, and that it is our duty to put up something for the provinces to give their decision upon.

Mrs. CASSELMAN: Mr. Chairman, does it not come down to the old riddle: "Which came first, the hen or the egg?" It seems to me that there is no point to that riddle. Which comes first, the provinces or the federal government? Make a beginning somewhere, and no matter where you make your beginning you will make progress.

Hon. Mr. BRUCE: Nobody appreciates more than I do the very valuable work that has been done by Dr. Heagerty and his committee, and as a medical man I desire to pay tribute to that work. Dr. Heagerty has gathered together an enormous amount of information which cannot be other than helpful in the final decision as to the kind of bill that will be introduced in this house and accepted by the provinces; but I feel there has to be an understanding and cooperation between the dominion and the provinces, and the sooner they have a meeting to consider some of these financial problems particularly, which bear so heavily on the provinces, the more expeditiously will we get on with this bill.

The CHAIRMAN: That is assured.

Mr. KINLEY: Have we invited the representatives of the provinces to come to Ottawa?

The CHAIRMAN: They were here last year.

Mr. KINLEY: But more often? What has Dr. Bruce in mind?

Hon. Mr. BRUCE: A consultation between the dominion government and the provincial governments.

Mr. JOHNSTON: Were the representatives of the departments of health of the provinces here last year?

The CHAIRMAN: Yes, they were all here. One or two of them did not present briefs because they said the man who spoke ahead of them spoke for them. They had a conference before they came here and agreed upon a speaker.

Mr. KINLEY: Maybe you ought to invite them again?

The CHAIRMAN: I would like to ask Dr. Heagerty a question. On page 7, section 5, you refer to a "professional training grant," and you state:

The original amount suggested for distribution to the provinces to enable them to provide public health training for physicians, dentists, nurses, etc., was placed at \$100,000.

Is the grant for this sort of training for professional personnel returning from overseas authorized in order in council P.C. 7633?

Dr. HEAGERTY: I am not familiar with that order in council.

Hon. Mr. MACKENZIE: Any profession at all. We have some doctors now going through university taking courses under the benefits of P.C. 7633, with tuition fees paid, and under the order in council they can take not only their degree but may proceed to postgraduate courses if they are making good progress in the ordinary graduate courses.

Mr. KINLEY: And general assistance under the vocational plan.

Mr. McCANN: Referring to page 6 of the submission, section 4, dealing with the amount of the venereal disease (control) grant, I see:

The amount of the venereal disease grant should be \$1,000,000 a year for a period of ten years, to be divided annually as follows:

- (a) 50 per cent distributed on the basis of population as shown in 1941 census; and
- (b) 50 per cent distributed according to the number of new cases of venereal disease reported in the previous calendar year, as certified by the dominion statistician.

This grant to be made on condition that each province matches its share of the grant by an equal amount.

Some few years ago, my recollection is, the grant for that purpose following the last war, when the incidence of venereal disease was greatly increased during the war and in the years immediately after the war, was \$500,000.

Hon. Mr. MACKENZIE: It was \$200,000 in 1919 and was abolished in 1932 and a grant of \$50,000 was given a few years ago, which was supplemented by \$175,000; the total last year was \$200,000.

Mr. McCANN: Did the various provinces avail themselves of the opportunity of taking that grant to the full amount? My understanding was that at the time of the grant it had to be matched by an equal amount.

Mr. MARSHALL: That is right.

Mr. McIVOR: I would like to ask a question: Will conscientious objectors have to comply with the conditions of this bill? When the Christian Scientists presented their brief last year I understood they did not want to have anything to do with it. Will everybody have to be subject to this bill?

Dr. HEAGERTY: Under this draft Bill everybody will be obliged to contribute, but nobody will be forced to accept the benefits provided by the Bill. On page 12, section 5, subsection (1) of the draft Bill, it is stated:

5. (1) Except as provided in this section and section six of this Act, every adult shall pay to the health insurance fund a contribution of twelve dollars in each year in such manner and at such time and place as may be prescribed.

There are no exceptions.

Mr. McIVOR: Whether they make use of it or not?

Dr. HEAGERTY: Yes.

Hon. Mr. BRUCE: When it comes to a question of venereal disease perhaps they will get the protection they would like to have by contributing.

Mr. McCANN: I want to ask another question with reference to the raising of the total amount of money necessary. I might point out, in view of some of the former discussions here, that out of the \$250,000,000 expenditure in one year the federal government is paying three-fifths, \$100,000,000, which the finance committee recommend. On page 1 of the submission it is stated:—

. . . . the committee recommend a plan for financing of health insurance under which the dominion would assume roughly \$100,000,000 as its share of the cost, plus the task of collecting an additional amount of roughly \$50,000,000 on behalf of the provinces. . . .

Of the \$50,000,000 to be collected by way of income tax, how much comes from income tax of people over the limit of \$3,000? The reason I ask that question is because I anticipate that there may be some objection to that particular phase of the method of financing, and the way that we could meet objection probably could be by making it a matter of choice as to whether people with an income of a stated amount, \$2,400 or \$3,000, would take advantage of the provisions of the health insurance Act or not. I would suggest, for the purposes of discussion only at the present time, that perhaps it might be made optional that a man with an income of \$3,000 and up comes under the scheme; that he pay the basic rate of \$12 per year for himself and his wife and children over sixteen years of age, but would be relieved of the tax if he had an income of over \$3,000. I want to know what amount of that \$50,000,000 comes from income taxpayers with an income of over \$3,000 a year.

Mr. MARSHALL: That is a question we cannot answer because no one has access to the income tax returns.

Mr. McCANN: Something like 94 per cent of the people of this country have an income of less than \$3,000 per year, I think, so that it should be comparatively easy, if we could get the data, to figure out what amount of money comes from people who have an income of over \$3,000 per year.

Mr. BOYCE: Our statistics on the distribution of income tax are not up to date. I believe the Income Tax Division is now revising its statistics on income tax collections, and we hope to have some figures applying to the year 1942, within some months anyway, because it helps us with the budget. I think when those figures come out it would help very much in answering the question, but the only figures we have that would answer the question at present are figures that relate to a number of years ago. I would say, on the whole, that the amount collected under this contribution of income from those over the \$3,000 income level would be significant but not a high proportion of the \$50,000,000. Whether it would be \$5,000,000 or \$10,000,000 I would not like to try to guess, but I would say it would be that order of magnitude rather than half the total.

The CHAIRMAN: Are there any other questions?

MR. ADAMSON: There has been some criticism in the press and I would like to quote one sentence from the Toronto Saturday Night, in which there appears a long article on Health Insurance:

We know that it is going to cost us \$74 per annum, and that is about all. What the average citizen is going to get for his \$74 remains a complete mystery.

I would like Dr. McCann's question discussed further. I have received a number of letters indicating that opposition to this bill is being built up, a very strong opposition which is growing. I am entirely in favour of health insurance, but I think some clarification of the cost to the individual should be brought down in this committee and made public throughout the country. I am receiving letters from the fixed income group of \$25 and \$50 per week who should really be the ones to benefit from this Act, and either they have not understood it or there is growing feeling definitely against it throughout the country.

HON. MR. MACKENZIE: May I read out the tables showing the amounts payable in contributions under the revised scheme by persons of various income levels?

MR. ADAMSON: If you please.

HON. MR. MACKENZIE:

Tables showing the amounts payable in contributions under the revised scheme by persons of various income levels:

Single persons pay basic fee of \$12 regardless of income, plus following levies:

Income	Income Levy	Total
*\$ 660 and under.....	.....	\$12 00
700	\$ 1 20	13 20
800	4 20	16 20
900	7 20	19 20
1,000	10 20	22 20
1,100	13 20	25 20
1,200	16 20	28 20
1,300	19 20	31 20
1,400	22 20	34 20
1,500	25 20	37 20
1,600	28 20	40 20
1,660 and up.....	30 00	42 00

Married persons or those with one adult dependent pay basic fee of \$24 plus following levies:—

*\$1,200 and under.....	.....	\$24 00
1,300	5 00	29 00
1,400	10 00	34 00
1,500	15 00	39 00
1,600	20 00	44 00
1,700	25 00	49 00
1,800	30 00	54 00
1,900	35 00	59 00
2,000	40 00	64 00
2,100	45 00	69 00
2,200 and up.....	50 00	74 00

* Less an abatement allowed under provincial regulations because of inability to pay.

MR. SLAGHT: Does that include the \$24 or otherwise?

HON. MR. MACKENZIE: It includes it.

MR. LECLERC: Does that refer to a man with a wife and daughters at home?

HON. MR. MACKENZIE: All children under sixteen years of age are paid for by the dominion government.

Mr. MACINNIS: I think this matter should receive a great deal of thought. The first item in the table is \$12 for everyone in receipt of an income of \$660 and under. Exactly what does that mean? Does it mean that any people in receipt of \$320 or \$350 per year would also have to pay \$12 for medical services? If that is the case we are not improving the health of the people. I think if we are going to base it on some monetary value it would be better to base it on the amount that each individual adds to the national income, rather than on what each individual in our competitive system takes out of the national income. I think that would be a fairer way of distributing the burden of health insurance. Personally I believe the best way to deal with this matter would be to establish a flat percentage on the income tax after allowing a certain amount, as we do now, without deductions at all, and then we would pay for this the same as we pay for everything else, including the war, namely, on our ability to pay. We are not improving the general health of the people if we compel those who are not now receiving sufficient to maintain health to contribute a certain amount of what they do receive to the general bill for medical health services.

Hon. Mr. MACKENZIE: Your point is partly met by section 6, subsection 1, of the proposals:—

6. (1) Where the income of a contributor is less than an amount prescribed, the contribution otherwise payable by him under section five of this Act may, upon application, be reduced by such amount as the commission may determine in accordance with the prescribed regulations.

So there is an approach to your suggestion in the bill now.

Mr. GERSHAW: The dominion now looks after children under sixteen years of age. What would be the additional cost if the dominion also looked after those now twenty-one years of age who are in school and university and not earning money in any way?

Mr. MARSHALL: We shall have to get the statistics as to that and submit them later.

Mr. JOHNSTON: What is the average contribution for health insurance?

Hon. Mr. MACKENZIE: \$21.60.

Mr. MARSHALL: The estimate of the Committee on Health Insurance costs was \$21.60.

Mr. JOHNSTON: What does the ordinary civilian now contribute?

Hon. Mr. MACKENZIE: That is the average, \$21.60.

Mr. LOCKHART: I assume that the finance committee has given very careful consideration to the collection of this money? With small industries having their capital surplus reduced to a very great extent in these days, does the committee feel that there is no other way of collecting this money than by loading it onto the small individual industries?

An Hon. MEMBER: No; that is out.

Mr. LOCKHART: What is the opinion of the committee as to collection?

Mr. MARSHALL: It was the opinion of the committee that as the collection was to be made by the provinces, no decision should be made on this point before consultation with the provinces. Conditions are so varied in Canada that what might be a suitable plan in Prince Edward Island might not work in, say, Montreal or Toronto.

Mrs. CASSELMAN: The minister has given a total of \$74 for a man and his wife. What about dependants over sixteen years of age? Is the total still to be \$74, no matter how many dependants there are?

Hon. Mr. MACKENZIE: \$12 more for each adult over sixteen years of age.

Mrs. CASSELMAN: As it moves up to \$74 the \$12 is added as a flat rate?

Hon. Mr. MACKENZIE: Yes.

Mr. LECLERC: Say there are a couple of daughters at home over sixteen years of age who are not working, how would they be classed?

Mr. MARSHALL: They would be dependants, and they would be liable to pay the \$12 contribution.

Mr. WOOD: I wonder whether any consideration has been given to the feasibility of earmarking a tax on those things which are used that have a tendency to impair the nation's health?

Mr. McKINLEY: It all goes to show how necessary family allowances are.

The CHAIRMAN: The committee would like to have some further amplification of the financial structure of the proposed bill. The next time we meet I think we should have further amplification from Mr. Marshall.

Mr. SHAW: Is there any particular reason why such reports cannot be made available to members of the committee before we come into committee meeting? It is difficult to examine these matters and give them proper consideration, and frequently we have to refer back to the draft bill.

Hon. Mr. MACKENZIE: Yes, that can be done.

The CHAIRMAN: We shall adjourn to the call of the chair.

The committee adjourned at 1 o'clock to meet at the call of the chair.

Dr. J. J. Heagerty
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Session - Social Security, 1944
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SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 3

THURSDAY, MARCH 16, 1944

WITNESSES:

- Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
- Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of Statistics;
- Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
- Mr. R. B. Bryce, Financial Investigator, Department of Finance;
- Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
- Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;
- Mr. A. D. Watson, Chief Actuary, Department of Insurance.

OTTAWA
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PRINTER TO THE KING'S MOST EXCELLENT MAJESTY.
1944



MINUTES OF PROCEEDINGS

THURSDAY, March 16th, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present;—Messrs.,—Adamson, Blanchette, Bourget, Breithaupt, Bruce, Casselman (*Mrs.*), Côté, Donnelly, Gershaw, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Lockhart, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Mayhew, Picard, Slaght, Veniot, Warren and Wright—28.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of Statistics;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission; and

Mr. J. E. Howes, Research Staff, Bank of Canada.

The following witnesses were called, examined and retired:—

Dr. J. J. Heagerty,

Mr. J. T. Marshall,

Mr. H. C. Hogarth,

Mr. R. B. Bryce,

Mr. W. G. Gunn,

Mr. E. Stangroom, and

Mr. A. D. Watson.

On motion of Mr. McCann the Committee adjourned at 1.05 o'clock p.m., to meet again at the call of the Chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,
March 16, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. The Chairman, the Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Gentlemen, the minister will make a brief statement this morning before we call on Mr. Marshall.

Hon. Mr. MACKENZIE: Mr. Chairman and gentlemen, at page 44 of the proceedings of the committee, Dr. McCann asked this question: "I want to know what amount of that \$50,000,000 comes from income tax payers with an income of over \$3,000 a year." Our finance committee have prepared a very detailed memorandum. It is rather too detailed for me to read to you, but I will read the last submission on the back page, and it will be placed upon the record, with your permission.

The CHAIRMAN: Very well.

Hon. Mr. MACKENZIE: Then Mr. Marshall can explain the significant facts in it. The important part is in the last page of this memorandum, which is very brief, and which I shall read. It is as follows:

"In answer to the question by Mr. J. J. McCann at the meeting of the Committee on Social Security of the House of Commons on March 9, 1944, namely:

'What amount of that \$50,000,000 comes from income taxpayers with an income of over \$3,000 a year?'

"the committee on health insurance finance begs leave to report that the taxation division of the Department of National Revenue estimates that if all persons, single or married, with income over \$3,000 a year were exempted from payment of the three and five per cent contribution for health insurance, the payments so exempted would amount to about \$9,000,000 and would cover approximately 185,000 taxable persons."

There are detailed tables on the first two pages, Mr. Chairman.

The CHAIRMAN: I think possibly Mr. Marshall had better explain them.

Hon. Mr. MACKENZIE: He can do it better than I can for the committee.

The CHAIRMAN: Then, Mr. Marshall, will you do that?

Mr. MARSHALL: Mr. Chairman and gentlemen, on the first statement Submission "A", we have endeavoured to estimate the annual operational cost of health insurance and the distribution of how it would be collected. We took the figure

Hon. Mr. BRUCE: Will you speak louder, please?

Mr. MARSHALL: I will try to. We took the figure which was originally estimated as the per capita health insurance cost, \$21.60; but we have not had time as yet to examine that figure in full detail. On the population at the present time, it would require an operational cost of, roughly, \$242,235,000. The estimated yield from the contribution of \$12 per insured adult would bring in an amount of \$94,480,000. The estimated residual amount from health insurance contributions collected by the Dominion Income Tax machinery on behalf of the provinces as a percentage on income, and the amount from the

Dominion Grants would amount to somewhere in the neighbourhood of \$147,-755,000. We have endeavoured to break that down by provinces, and it would be put on the record, unless you would like me to read in the particular amounts for each province.

Hon. Mr. MACKENZIE: I think the total by provinces would be very interesting to the committee.

Mr. MARSHALL: Very well, I shall read this. I am sorry we could not get these reports mimeographed for the committee as requested by one of the members at the last meeting, but I may say that this was not finished until 10.30 o'clock this morning. I will now read this. It is as follows:

ESTIMATED ANNUAL OPERATIONAL (1)COST OF HEALTH INSURANCE
(Thousands of dollars)

Province	Est. operational cost at \$21.60 per capita (2)	Est. yield from contribution of \$12 per insured adult (3)	Est. residual amount from health contri- butions collected by Dominion income tax (4) and from Dominion grants
Prince Edward Island	2,021	761	1,260
Nova Scotia	12,208	4,654	7,554
New Brunswick	9,725	3,558	6,167
Quebec	70,727	25,943	44,784
Ontario	79,752	32,663	47,089
Manitoba	15,183	6,055	9,128
Saskatchewan	18,874	7,117	11,757
Alberta	16,740	6,444	10,296
British Columbia	16,753	7,187	9,566
Yukon	73	33	40
North-West Territory	179	65	114
TOTAL	242,235	94,480	147,755

- (1) Excludes administration costs to be borne by the provinces under the plan.
- (2) Based on 1941 census population figures excluding Indians, pensioners in hospitals and permanent inmates of homes and similar institutions, estimated to number 292,061 for the Dominion. The per capita cost figure of \$21.60 is that given in the data of "Tentative Estimate of Costs of Health Insurance, etc.", presented to the Special Committee on Social Security at the 1943 session.
- (3) Individuals over 16 years of age less Indians, pensioners, etc., estimated to number 208,981 for the Dominion. These sums to be collected by the provinces.
- (4) The amount of contributions based on taxable income and collected through the Dominion income tax machinery is estimated at about \$50 million, leaving a residue of about \$100 million to be provided through the Dominion health insurance grant.

ESTIMATED REVENUE FROM HEALTH INSURANCE CONTRIBUTIONS
THROUGH INCOME TAX COLLECTIONS—1942

Single Contributors				
Income range	Average amount subject to levy	Average contribution at 3%	Estimated number of contributors	Yield in contributions
\$ 660—\$ 700	\$ 20	\$ 60	35,000	\$ 21,000
700— 800	90	2 70	101,000	272,700
800— 900	190	5 70	87,000	495,900
900— 1,000	290	8 70	77,000	669,900
1,000— 1,100	390	11 70	69,000	807,300
1,100— 1,200	490	14 70	55,000	808,500
1,200— 1,300	590	17 70	49,000	867,300
1,300— 1,400	690	20 70	39,000	807,300
1,400— 1,500	790	23 70	31,000	734,700
1,500— 1,600	890	26 70	26,000	694,200
1,600— 1,660	970	29 10	14,000	407,400
Over 1,660	1,000	30 00	94,000	2,820,000
			677,000	\$ 9,406,200

Married Contributors

Income range	Average amount subject to levy	Average contribution at 5%	Estimated number of contributors	Yield in contributions
\$1,200—\$1,300	\$ 50	\$ 2 50	94,000	\$ 235,000
1,300—1,400	150	7 50	112,000	840,000
1,400—1,500	250	12 50	110,000	1,375,000
1,500—1,600	350	17 50	115,000	2,012,500
1,600—1,700	450	22 50	122,000	2,745,000
1,700—1,800	550	27 50	108,000	2,970,000
1,800—1,900	650	32 50	99,000	3,217,500
1,900—2,000	750	37 50	85,000	3,187,500
2,000—2,100	850	42 50	71,000	3,017,500
2,100—2,200	950	47 50	55,000	2,612,500
Over 2,200	1,000	50 00	352,000	17,600,000
			1,323,000	\$39,812,500
			Estimated number of contributors	Estimated contribution
Single			677,000	\$ 9,406,200
Married			1,323,000	39,812,500
			2,000,000	\$49,217,700

I may say that this second sheet has been the work of the income tax division, and we are indebted to Mr. Hogarth for supplying us with this material.

Mr. McCANN: As to the 185,000 persons who would be under this scheme, income tax payers on over \$3,000, is there a breakdown of where they are located, by provinces?

The CHAIRMAN: Can you answer that, Mr. Marshall?

Mr. MARSHALL: We do not have that information at the present moment, Mr. Chairman. I do not know whether that would be possible. Could I leave that question to Mr. Hogarth? He might be able to tell us whether that would be possible.

Mr. DONNELLY: Have you made any estimate as to what it would cost the provinces in administering the act?

Hon. Mr. MACKENZIE: I was just going to ask that very question.

The CHAIRMAN: Mr. Hogarth.

Mr. HOGARTH: I could not say at the moment whether we can break that down by provinces or not. We can have that information for another meeting.

The CHAIRMAN: We will try to get that, Dr. McCann.

Hon. Mr. MACKENZIE: Dr. Donnelly's question is a very interesting one. Is it possible to compute how much this would cost the provinces? First of all there is the cost of operation which would work out at 5 per cent in that formal report. Then there is the incidental cost of abatement for the individual who cannot pay \$12. I suppose it is impossible to make any computation as to what it would cost British Columbia, Ontario, Prince Edward Island or New Brunswick on these figures, or can you make a rough approximation of it?

Mr. MARSHALL: I think that is a pretty hard thing to figure out unless you make a complete dominion-wide survey. I do not think any estimate we could make would be one which you could place much reliance on.

Mr. JOHNSTON: Could you compare it with the old age pension in any way, because they do collect on that?

Mr. MARSHALL: It is difficult, Mr. Chairman, to estimate what the provinces will do with abatements.

Hon. Mr. MACKENZIE: At the present time you know what they pay in each province for their indigents and their hospitalization. That would be embraced in this new scheme, would it not?

Mr. MARSHALL: We tried to figure that out before, and it was a difficult problem. I am speaking from memory now, but I think for hospital grants and indigent medical services in 1938 the provinces and the municipalities spent in the neighbourhood of \$15,000,000, that is as close as we could find out from the information that was available in the public accounts of the provinces.

Hon. Mr. MACKENZIE: If they pursue the same policy, more or less—and I am speaking in a very broad way now—in regard to hospitalization and indigents, and the 1938 figures applied to it, the only additional cost to the provinces would be the cost of the operation of this scheme. Would that not be so?

Mr. DONNELLY: Hospitalization would not be any guide, because the hospitals get so much per patient whether they pay their way or not.

Hon. Mr. MACKENZIE: I know that.

Mr. McCANN: No, only on the ones who do not pay their way.

Mr. DONNELLY: No. In Saskatchewan and western Canada the hospitals get so much a patient, whether they are indigent or not.

Mr. McCANN: That is not so in Ontario. They pay only on indigents. They do not get any grant for a private patient.

Mr. HOWDEN: This is very difficult material to follow; for those of us who are getting a little old and a little deaf, it would be a great matter of charity if the speakers would speak a little louder. We just do not hear them, that is all.

The CHAIRMAN: Would you speak a little louder, if possible?

Mr. MARSHALL: Yes, I will try.

Mr. GERSHAW: For the plan proposed, and having regard to the \$12 contribution collected by the provinces, can they raise that money in any way they like? Suppose they decide to take it all out of provincial taxation. Would they be eligible under the present plan if instead of trying to collect it from the individual, they collected it all by general taxation?

Mr. MARSHALL: Mr. Chairman, I think I speak for the committee on this. It is something we have discussed in a general way. We feel that the \$12 contribution is the key to administration. We have not talked this over officially with the provinces, but we have had some advice from the deputy ministers unofficially. That is how we could get everybody registered. We feel that you must register the population at local areas. We feel also that probably the same collection machinery should be used in distributing the benefits, so that you have your whole administration in the one place in the local areas. The administration must know those who are eligible to benefit, and we feel that the \$12 contribution collected by the province is really the key to that situation.

Mr. JOHNSTON: Do I understand that you are going to force the provinces to collect this \$12 from each individual rather than paying it out of the general taxation if they wish to? I should think that would be extremely unfair, because some provinces may say, "Here, the administration of collecting this from the individual is going to be far greater than it really should be." Therefore they would prefer to take it out of the general taxation, rather than make the individual pay it. I think that should be left to the provinces.

Dr. HEAGERTY: I wonder if I may be permitted to answer that question. If you refer to page 12, section 5 (1) under the title of "Contributors" you will

find the following clause: "Except as provided in this section and section six of this Act, every adult shall pay to the health insurance fund a contribution of \$12 in each year in such manner and at such time and place as may be prescribed." Therefore it is expected that every individual shall make a contribution of \$12. But if you refer again to section 4 on page 3 of the Dominion bill, you will find that it is the privilege of the province to make statutory provisions, and that those statutory provisions shall be substantially in the terms that are laid down in the provincial sections of the bill. It would be possible for a province to modify the provincial bill in such manner as it may wish, to the satisfaction of the Lieutenant Governor in Council and the Governor in Council. That is a matter for arrangement between the Lieutenant Governor in Council and the Governor in Council. There is nothing hard and fast about the provincial section of the Bill. It is a model and may be modified to the satisfaction of the province and the dominion.

Mr. JOHNSTON: Even so, I think that is going a little farther than it should go. I think the draft bill should be changed in that regard. Even though on page 4 it is left to the approval of the Governor General in Council, it would seem to me that the Governor General in Council then would have the power to force the provinces to collect this from each individual, although it may be against the setup in the province and it may be against the wishes of the province. If the Governor General has that power to dictate to the provinces the manner in which they may collect this, then I think that would be wrong. I think the greatest length to which the dominion should go is to see that the money is collected.

Dr. HEAGERTY: This, of course, is health insurance and public health. Under the British North America Act the dominion has no jurisdiction in regard to one or the other. Therefore I would say that it has no jurisdiction to state how the money shall be collected for the provision of medical and public health services that are exclusively provincial in character.

Mr. DONNELLY: It can be done only by agreement.

Dr. HEAGERTY: By agreement and co-operation.

Mr. MACINNIS: May I ask if the finance committee has given any consideration to a flat income tax rate for financing the whole structure, as compared with a levy on an income tax basis?

Mr. MARSHALL: Yes, Mr. Chairman. That was one of the schemes that the finance committee considered in quite a lot of detail. We felt that if you put in that type of plan, it would not be contributory. You would not have contributory health insurance. Another thing, you would not be able to add old age pensions to the administration plan—that is contributory old age pensions—if that is desired at a later date. Another thing is this. I do not know that you can call it making the provinces do certain things. It is rather that a principle is involved. I would say that it involves assessing everybody with income below the income tax exemptions. It would mean you would have to go completely down to the man whose annual income would be \$100 a year.

Mr. WRIGHT: Not necessarily. I do not see how it necessarily follows that you would have to go down to the lower incomes. You could start your levy on the same basis as you have it at the present time, at \$660 or \$1,200. It would simply mean that people under that would be getting medical services free; that is, as far as contributing personally was concerned, outside of what they would pay by way of general taxation. Have you any figures as to just what that would mean or what it would cost in a levy such as that?

Mr. BRYCE: Mr. Chairman, you can get that from the figures that Mr. Marshall read. It would mean eliminating the large bulk of the \$94,000,000

collected from the \$12 contribution a head for adults; that is to say, the bulk of the contributions under the health insurance scheme here are the \$12 contributions, which are either paid or which are abated by the provinces and paid by the provinces out of general revenue.

Mr. McCANN: What do you mean by the "bulk" when in the aggregate it is only \$94,000,000 and the full cost is \$250,000,000?

Mr. BRYCE: I mean the bulk of the contributions paid.

Hon. Mr. MACKENZIE: The contributions, not the grant.

Mr. McCANN: Oh, I see.

Mr. DONNELLY: You collect only about \$50,000,000 from the incomes?

Mr. BRYCE: That is right; from the levy on incomes.

Mr. DONNELLY: The other \$100,000,000 is given by the dominion, which probably comes from the income tax as well?

Hon. Mr. MACKENZIE: From the general revenue.

Mr. DONNELLY: \$150,000,000 comes from the general revenue, the income tax or whatever you like to call it, and \$100,000,000 from the people by their contributions.

Hon. Mr. MACKENZIE: That is right.

Mr. MACINNIS: I think Mr. Marshall said if we adopted the straight income tax way of raising the money, we would have to levy income tax on everybody, even persons receiving an income of \$100 year. Of course, that would be preposterous. But will you not have to do the same thing if you raise \$12 each from individuals? Where are you going to draw the line for raising \$12? At what particular income range are you going to draw the line?

Mr. MARSHALL: You only abate beneath the present income tax level where there is an application received by the provincial health insurance commission; and they would have to set a standard for abatement in certain income levels in each province.

Mr. JOHNSTON: What increase in the dominion income tax rate would there be if you collected this all from income tax? What would be the increase in rates? I think it would be extremely small.

Mr. BRYCE: If I can recall it, the present income tax, on present incomes, was estimated in the last year to yield something of the order of \$900,000,000. That includes the refundable portion of the tax. The portion aside from the refundable portion, I suppose, would be something of the order of \$700,000,000, so that the total cost of this health insurance scheme would exceed one-third of the present income tax, apart from the refundable portion.

Mr. DONNELLY: You would have to increase it by one-third?

Mr. BRYCE: Yes, with present incomes, by one-third. If you take it that after the war the income tax will yield something less than it does at its wartime peak, then the increase necessary in the income tax to carry health insurance by that means would have to be more than one-third; and the possibilities of increase, of course, are going to be greater on the lower income tax ranges than in the upper ones; that is to say, you cannot increase the tax on the higher brackets by one-third. Consequently, it would involve a greater increase on the lower brackets than that. I think that is about the best I could estimate, right off the bat.

Hon. Mr. MACKENZIE: Is not contribution the very essence of insurance? Can you have insurance without contribution?

Mr. DONNELLY: Without contribution, it is not insurance.

Hon. Mr. MACKENZIE: No.

Mr. JOHNSTON: Is it not true that Australia decided on this contributory type of health insurance at first, and now they have changed over to the non-contributory type?

Dr. HEAGERTY: Australia is studying the entire question of health insurance at the present time but has not as yet passed a Bill. New Zealand, as you know, has. Australia, however, has under consideration at the present time a bill dealing with health insurance for unemployed. A discussion has arisen in the Australian house as to whether such health insurance should be provided by contribution or by taxation. I do not know whether the majority are in favour of contribution or not, but that question has held up the bill. We believe, after a great deal of thought and discussion, that each individual who is insured should make a contribution. It is his money. It is his plan. He will be the individual who will obtain the benefits. You will remember, Mr. Johnston, that at one time you raised the question of charity as a solution of security. You said that you did not believe in charity as a satisfactory measure. I do not believe in charity either as a substitute for security.

Mr. JOHNSTON: That is right.

Dr. HEAGERTY: And I do not believe in assistance. What you are recommending is assistance and not security. What we are working for is security. Therefore we as a committee believe that every one should make a reasonable contribution.

Mr. JOHNSTON: May I just correct that, Mr. Chairman. I am recommending security, absolutely; and I want to put the people in a position where they do not feel that they are receiving charity. When Dr. Heagerty says that I am recommending assistance rather than economic security, I think that is just exaggerating the point a little bit, because I certainly believe in economic security, regardless of the financial status entirely. I believe that everybody should be given this regardless of whether they are able to contribute or not. It should not depend on their financial circumstances. That is why I think the fairest way to do it would be through income tax, because we have always accepted that as being the most fair way of levying taxes—on the ability to pay. This plan does not go according to ability to pay, because the proposition starts out with single persons at \$700, who pay a levy of \$1.20. Then it goes up to \$1,600, under single contributors, and you pay a levy of \$30. Under the married class you start in at \$1,300 and you pay a levy of \$5. Then you go up to \$2,200 and pay a levy of \$50. In effect that means that those with an income of \$2,200 in the married class pay a levy of \$50 or a total of \$74. Those above that income pay exactly the same rate. If it is based on the ability to pay, of course those in the higher brackets should be paying more and it would not be stopped at \$2,200. I think that the principle should be that of ability to pay,—that would be my whole argument,—and that the thing should not be contributory but should be non-contributory. I am sorry I did not bring the clipping down. It was shown to me, and indicated that Australia had changed over to the non-contributory type. I saw that in the press yesterday and I was going to bring it down with me and ask you about it, but I have mislaid it. Mr. Shaw, the member for Red Deer, had it and showed it to me, but I see he is not present yet. He is in another committee. I wish I had brought it down.

Mr. STANGROOM: I noticed something about the Australian bill the other day. The Australian bill is a joint cash assistance and cash sickness benefit; it is mostly for indigents and it is non-contributory, but it has a means test and it has a responsibility test. In other words, it is a relief scheme. I understand that the Australian senate voted it down and referred it back as being against the general principle of social insurance.

Mr. DONNELLY: What is the tax in New Zealand in connection with income tax—5 per cent on all income tax?

Dr. HEAGERTY: A registration fee annually of five shillings for all persons up to the age of sixteen; and after that age 10 shillings and 5 per cent of income for all security measures.

Mr. DONNELLY: Does it start at the bottom and go up?

Dr. HEAGERTY: The government of New Zealand contributes one-third of the cost. By the way I was not referring to the statement of Mr. Johnston when I distinguished between assistance and security, but I was pointing out that assistance is really a form of charity and that it stems from the middle ages. There are some in the welfare field who think we should continue to give charity, whereas most of us are trying to assist people to help themselves rather than give them a handout. That is what I had in mind.

The CHAIRMAN: Mr. Marshall, have you any clarification to make on this point?

Hon. Mr. MACKENZIE: There is this point: suppose we had a provincial conference to-morrow regarding the financial provisions, could we give any approximation, say, to British Columbia or New Brunswick or Ontario or Quebec or to any of the other provinces as to how much it is going to cost them?

Mr. DONNELLY: That is what is disturbing me—to know whether the provinces are paying their part. How much are they going to have to pay?

Hon. Mr. MACKENZIE: It is obvious that this is much easier than the scheme of last year. Last year we were only contributing \$40,000,000 directly and this year we are contributing \$100,000,000 directly from the Dominion treasury; therefore this scheme is much easier on the provinces than was the one of last year.

Mr. DONNELLY: We know that the provinces have a surplus; the Dominion Government is the only one that is going into debt.

The CHAIRMAN: Mr. Marshall, can you enlighten us?

Mr. MARSHALL: As far as one can estimate, Mr. Chairman, the provincial governments would be required to provide about \$15,000,000, which would be offset, of course, by that other amount.

Hon. Mr. MACKENZIE: That is for hospitalization and indigents both, and you have added to that 5 per cent for administration.

Mr. MARSHALL: These are not our estimates; these were done by another branch, but this is the best we can get.

Hon. Mr. MACKENZIE: Would you not add 5 per cent for administration?

Mr. MARSHALL: Yes.

Hon. Mr. MACKENZIE: What is the total of that?

Mr. MARSHALL: Originally, by the other committee, it was about \$24,000,000.

Mr. BRYCE: About \$12,000,000 now.

Hon. Mr. MACKENZIE: \$12,500,000, roughly speaking. The total cost to all the provinces combined would be about \$22,500,000.

Mr. MARSHALL: As far as we can make out.

Hon. Mr. MACKENZIE: And of that amount practically \$15,000,000 is being paid by them now for hospitalization and indigents, so that the additional cost to the provinces with certain exceptions will be \$12,500,000, and that would include 5 per cent for administration.

Mr. MARSHALL: Administration under the original plan was figured at \$22,000,000.

Hon. Mr. MACKENZIE: That was last year. We have given that up. It is 5 per cent now—half of that.

The CHAIRMAN: Dr. Donnelly asked just how that cost will be distributed among the provinces. Is not that your question?

Mr. DONNELLY: Yes.

The CHAIRMAN: Can anybody answer that?

Hon Mr. MACKENZIE: Supposing we assume that the additional cost would be \$12,500,000, how would it be distributed on a per capita basis among the provinces?

Mr. BRYCE: I feel that it is desirable not to create the impression that this thing is simpler than it is in fact. The cost to the provinces is going to consist, in the first place, of the administration cost. It is possible to make a rough approximation of that on the basis of 5 per cent from the figures that were supplied in the first table. The second and more important element in the cost is the degree to which the provinces abate the \$12 payments to be collected. Those will depend presumably on the policy that a province follows in making abatements, how severe it wishes to be in judging the ability to pay of its citizens. It will also depend upon the incomes and the general economic conditions in a province in the year in question. I think it would infer too great a simplicity to attempt to say that the Dominion could estimate just how much will be abated by the provinces in these circumstances. However, taking the total figure for the \$12 contributions of \$94,000,000, it would seem surprising if they were normally going to abate more than, let us say, 20 or 25 per cent of that. So it seems to me hardly likely that the abatement in a normal year would exceed something like \$15,000,000 or \$20,000,000, but the distribution of that between the provinces may be quite uneven because of the greater wealth of some provinces than others, which would mean a greater number below the line of ability to pay the \$12 in some provinces.

Mr. DONNELLY: How much will the different provinces save in the way of looking after the tubercular cases and the insane patients, looking after their grants to hospitals—how much will they save in the other way if it comes out of the other fund instead of coming direct from them as at the present time?

Dr. HEAGERTY: They would save only the amount we put before you last meeting: \$2,000,000 for the treatment of tuberculosis and \$2,500,000 for the treatment of mental diseases.

Mr. McCANN: Are they not supposed to be additional expenses? It is not an actual saving. They will expend that in addition to what they are spending.

Dr. HEAGERTY: Yes, but the province will not have to contribute that amount. We really believe that the provinces will not expend an additional amount, but a smaller amount, and will, perhaps, be able to utilize some of their funds for preventive services.

Mr. HOWDEN: I understand that the bill proposes that the federal government will make an agreement with the provinces on a \$12 basis per capita for adult capita. That is to be the basis of the agreement between the provinces and the federal government. Now, it may be, and I am inclined rather to think there will be many hundreds or thousands of families who if they have three or four adults in the family and are in the low income group will shy away from paying \$12 for four or five adults in the family because it will run them up to \$60, and I was wondering if it is competent for the provinces to make this \$12 levy at whatever figure seemed desirable or advisable to them as long as the ultimate agreement was based on the \$12 basis.

Dr. HEAGERTY: Yes, it is quite possible for the provinces to do that if they so desire.

Mr. DONNELLY: It seems to me that there should be more than \$2,000,000 spent by the different provinces for tuberculosis and insane asylums. As far as Saskatchewan is concerned, treatment in both cases is free; it is supplied to everybody; and surely the province must spend more than that.

Dr. HEAGERTY: The total amount expended for treatment of tuberculosis is approximately \$8,000,000 and on mental illness \$19,000,000.

Mr. DONNELLY: By the Dominion?

Dr. HEAGERTY: By the provinces.

Mr. DONNELLY: If we adopt this offer under the scheme all that will be saved to the provinces; they will save \$19,000,000 which has been spent now on insane asylums, and treatment of the insane.

Dr. HEAGERTY: No, they should be able to provide free treatment for everyone. At the present time they make a charge for treatment in some cases, but our objective is to give free treatment for everyone; and the reason for that is that it is impossible to make provision in general hospitals for full and complete treatment for tuberculosis and for full and complete treatment for mental illness, and yet under health insurance an insured person who suffers from tuberculosis or mental illness will be entitled to both, and I believe that this is one method of solving our problem of providing them with full medical care.

Mr. WRIGHT: Is there anything in the bill which provides for a case of national disaster in a province? Let us take a condition such as we had in Saskatchewan where there were complete crop failures over two or three years. That \$12 might become quite a serious problem as far as financing is concerned. Now, is there any provision in the bill to take care of circumstances of that kind?

Hon. Mr. MACKENZIE: No, I do not think there is. In a case like that I think the government would do as was done in other years—the dominion would assist the province to meet a national emergency.

Mr. WRIGHT: It seems to me that there should be something in the bill to provide for a case like that.

Mr. GUNN: I would suggest this as a possible measure to take care of that point. Clause 9 on page 5 contains a provision for the assistance of provinces, the financial assistance and other kinds of assistance to the provinces in certain special circumstances, and if you will observe the circumstances are set out in *a, b, c, d*, and so on. Under the circumstances set out in (1) *a, b, c, d*, the Minister may render assistance in these methods: Now, I shall read:—

- (a) in case of an emergency affecting the health of the people;
- (b) for any special investigation or inquiry;
- (c) as respects any specific problems of administration;
- (d) for the purpose of enabling any province to bring into operation any agreement hereunder with such province.

Those are the circumstances under which the minister or the government may render assistance. Then (2) states as follows:—

- (a) affording opportunities for consultation between professional and technical members of his staff and the members of the staff of the provinces concerned;
- (b) placing technical and professional personnel at the disposal of the provincial authorities;
- (c) making available to the provincial authorities drafts of regulations and forms and draft procedure for carrying into effect any agreement made under this Act;
- (d) making available for the purposes aforesaid, and subject to any regulations or orders made under this Act, such financial assistance as parliament may from time to time provide; and
- (e) such other means as he may deem necessary or expedient for the execution of the purposes of this section.

I suggest that under this particular clause parliament may provide money to take care of emergencies such as have been mentioned.

The CHAIRMAN: Mr. Wright, does that embody what you suggest?

Mr. WRIGHT: Yes.

Mr. AUTHIER: Do I understand that the \$8,000,000 for tuberculosis now provided by the provinces and the \$19,000,000 for mental diseases now provided by the provinces will still remain the responsibility of the provinces in addition to the cost of the insurance?

Dr. HEAGERTY: Yes, that is right.

Mr. AUTHIER: The only thing that it provides is the expense of treatment.

Dr. HEAGERTY: Free treatment.

With regard to the remarks of Mr. Gunn, I might point out that it was not the intention to make any provision in case of an emergency such as was referred to, and I doubt if the section referred to could be extended in that manner. For example, section 9 (1) reads "in case of an emergency affecting the health of the people;". The intention was to make special provision in the case of an epidemic but not in the case of a financial depression. However, if you will look at section 6 (1) of the Act, page 13, under the heading "Adjustment of Contributions" you will find there that where the income of a contributor is less than the amount prescribed, the contribution otherwise payable by him under section 5 of this Act may, upon application, be reduced by such amount as the Commission may determine in accordance with the prescribed regulations.

So the province might make a special abatement in the case of financial emergency.

Mr. WRIGHT: What I am getting at is that a province, if conditions were such as obtained in Saskatchewan, would not be financially able to make that abatement, and I think some provision should be made in the bill to take into consideration the financial policies of the different provinces in raising this \$12. It is going to be much easier for the province of Ontario, for instance, or the province of British Columbia, to raise this \$12 per individual than it will be in the case of Saskatchewan or possibly New Brunswick; and I think there should be something in the bill which would provide for a difference in the ability of the different provinces to raise this \$12 from individual citizens. In effect, the bill says that every province is equally able to raise the \$12 per individual, but I do not think that that is a fair statement or assumption.

The CHAIRMAN: Dr. Heagerty, do you think the clause you read from in the proposed bill would cover Mr. Wright's suggestion—the clause that Mr. Gunn read; you say it could not be interpreted that way?

Dr. HEAGERTY: It might possibly be that subsection (d), "for the purpose of enabling any province to bring into operation any agreement hereunder with such province", might be stretched to cover that point; but if we are going to include anything in the Bill to meet that problem then it should be very clear and very distinct. I do not think we should leave it to the interpretation of a section that was not originally intended for that purpose.

Mr. WRIGHT: I feel that there should be a section in the bill which would meet that need, because we must admit that there is a difference in the financial ability of the various provinces and of the individuals in the various provinces to meet this contribution of \$12, and I really think there should be some provision made in the bill for that.

The CHAIRMAN: You think that financial ability varies according to certain circumstances.

Mr. WRIGHT: I think so. We must admit that.

Mr. MARSHALL: On this point I think the rest of our committee agreed with me that it is rather outside of the ambit of health insurance and it is more a problem of national emergency, and if the province of Saskatchewan, which has

been used as an instance, needs aid it is up to the dominion to meet the emergency at that time by a special grant in aid, but it should not come under health insurance legislation.

Mr. JOHNSTON: I thought you said that would be covered. I thought you indicated a section in which that would be covered.

Hon. Mr. MACKENZIE: No.

Mr. JOHNSTON: Mr. Heagerty took exception to it; but I thought the matter was covered by that section.

Hon. Mr. MACKENZIE: That was a suggestion by Mr. Gunn.

Mr. JOHNSTON: It was one of these gentlemen.

Mr. WRIGHT: May I point out that it would not only be the occasion of an emergency, but it is something that we know right now, that there always has been a difference in the ability of the various provinces in this respect—there has been a different economic standing in various provinces and among the individuals of those provinces. I certainly think there should be some consideration given to that fact in their bill; there should be a definite clause in the bill.

Mr. WARREN: That would open up a fine field for argument in the provinces, and there would be no end to it, if you admit that.

The CHAIRMAN: I think Mr. Wright refers to emergencies within the provinces at certain times which emergencies affect the ability of the province to pay.

Mr. WRIGHT: Yes, that is correct.

Mr. WATSON: I think we should keep in mind what health insurance is about. Health services are personal needs and are similar to the needs for food, clothing, shelter, and other essential needs of life. The individual is ordinarily expected to provide for these needs of life out of his own resources, and if he should be unable to do that then he gets relief in one way or another. However, it does seem to me that if an individual is fully and reasonably able to provide for those minimum needs he ought to do so. The introduction of health insurance is not intended to furnish relief, as it were, but rather to afford an easy method of payment for certain essential personal needs of life. That is all that is intended to be done: to make available to the individual a pay-as-you-go method of taking care of the risks of ill health. Secondly, the case for providing special relief for the \$12 contribution is on no better grounds than making provision in advance for subsidies to provinces to provide for food, clothing and shelter for its population, in a case of a hard year or a depression. So I think there is not a good case for making special provision in advance, at least, for meeting the contribution of \$12 unless we are prepared at the same time to make provision in advance for providing people with food, clothing, shelter, heat, light and so on.

Mr. MACINNIS: I think the point raised by Mr. Wright raises anew the question as to a levy according to ability to pay as compared with an individual levy of so much per person. As Mr. Wright has pointed out, it affects the ability not only of the individual to pay but the ability of the province to pay, because if the individual is unable to pay then the province abates his payments, and if the burden becomes too heavy for the province then some other agency has to step in. Now, Mr. Watson and others referred to this bill before us as a health insurance bill or an insurance bill and not relief; well, it is partly one and partly the other. If you take unemployment insurance that is insurance for the persons who pay contributions, it does not affect persons who have not paid contributions; but there we are including everybody—those who pay contri-

butions and those who do not pay contribution. Secondly, it is not insurance in the ordinary sense of using that term for those who have not paid contributions. Those persons who have paid contributions are not entitled to services because of the contributions paid; consequently, they must be entitled to services for some other reason, and they are entitled to services because it is considered in the interest of the community to give them these services as it would not be a good thing for the community not to give those people those services for the simple reason that you cannot have sick people in a community unentitled to health services without imposing a cost in some way on the community. So we cannot put this matter on a strictly insurance basis. Besides, many of our people have not got proper access to the means of life to enable them to pay the levies either by way of contribution or by way of a tax. So somebody has got to pay the levy for them. I think what we should consider now is exactly how we are going to raise this money, because the point raised by Mr. Wright will undoubtedly put some provinces in a difficult position.

Mr. DONNELLY: I admit freely that there are circumstances which will arise within a province as arose within the province of Saskatchewan where in certain sections, as occurred in my section, we had no crop for ten years. Naturally, those people at that time were unable to pay. That is an emergency. I say that they must have assistance in some way from some outside authority in order to live, let alone pay for social insurance or legislation of this kind. But I do not see how you are going to pass legislation for one province and make a different set of conditions apply to another province. That cannot be done. It would make for confusion.

Mr. WATSON: Mr. Chairman, I should like to clear up the point as to what is and what is not social insurance. Now, a province may abate the \$12 to the vanishing point to certain individuals in certain years depending on the fortuitous circumstances of those individuals in those years; that does not in any sense make the measure any the less insurance. For example, take life insurance, which everybody understands well. In a great many life insurance policies there is a clause which provides for the waiver of premiums in the event of serious ill health. A person may be totally incapacitated for a period of years and the premiums are waived. Likewise, under health insurance, when a person enters health insurance there is no reason why it should not be thoroughly well understood that if in any particular year that individual is unable to pay the \$12 or any other contribution by reason of ill health or any other misfortune which overtakes him, it is clearly within the realms of insurance to take care of his contribution or any part of it by a general contribution out of taxation. There is no difficulty whatsoever under insurance in providing for fortuitous circumstances by the waiver of contributions in any year.

As we think of young people entering health insurance from year to year, as they leave our schools and universities their future is unknown to them as to health and as to prosperity and all those other things. If we charge them one uniform contribution that takes care of all those fortuitous circumstances, including the waiver of their own contributions in the event of hard circumstances, we are not in any sense departing from insurance, I submit.

Mr. WARREN: Mr. Chairman, this measure is not going to be any too popular in a lot of places throughout this country, and I think if you were to take away that contributory feature from the measure you would add to the unpopularity of it. Now, when you talk about costs, the \$12 contribution, it is only a domestic service, and it is only \$1 a month, and I think that that is something that ought not to be considered—to take away the contributory feature from this measure. I was pleased that the bill was changed so that employers now do not have to make contributions. I like that feature of it.

I am glad also that the contributions of the individuals were reduced to \$12. The \$26 contribution was considered too high among a good many people. But I do not think, generally speaking, that there will be much objection, or even any objection, to paying \$12 a year. Practically any person who is making a living at all will not object to paying \$12 a year for health insurance.

Mr. McIVOR: I am not a financier although I look after my own affairs—

The CHAIRMAN: You are fortunate.

Mr. McIVOR: —but I was wondering if this bill could not be handled the same way as mothers' allowances and old age pensions. Some members have been speaking about a group of people who would not have access to the good things of life. I hope the day will never come again when there will be in Canada people who will not have free access to the necessities of life. I think we can make this scheme workable.

Mr. WRIGHT: Coming back again to the point of the ability of the provinces to meet this \$12 cost, I take it that we are trying to set up a medical health scheme for Canada that will give us a reasonably uniform service right across the dominion. I am afraid that if we do not make some provision for extra assistance to certain provinces under certain circumstances, it will mean that in those provinces we will get an inferior type of medical service to what will be available in certain other provinces. I think that is something which we want to avoid, and which we should make provision for in the bill. The Rowell-Sirois report certainly gave us a review of the financial ability of the various provinces in the dominion to meet their obligations, and one of the recommendations in that report was that certain areas should receive additional assistance. Right at the present time they do not need it. I will admit that. As long as these conditions prevail, I think the Act as it is now can be carried out successfully. But I think we should make provision in the Act so that if conditions do change—and we must admit that they may change—some consideration can be given to those provinces that may find themselves unable to supply the services to their people that other provinces are able to give. I think that is only reasonable.

Mr. GUNN: Mr. Chairman, dealing with that point, may I say that I do defer to my medical friend Dr. Heagerty in matters of medicine and public health, but I am afraid I cannot defer to him in matters relating to the interpretation of a statute. I do maintain that there is provision in this particular clause that I read to meet such emergencies as the honourable member has mentioned. I might say, while I am on my feet, that it is physically impossible to visualize all possible contingencies and to allow for them in the statute. I think everyone will agree with that. The kinds of emergencies that have been mentioned may be of a varied nature. In this particular bill, there is provision whereby the Governor in Council may consider such unusual situations and consider applications from provinces for financial assistance to meet those conditions, whether for crop failures, epidemics or things of that kind. While it might be possible to introduce in specific language a provision to take care of crop failure in any province which had already committed itself under an agreement, it does seem to me that it is opening the door pretty wide by excluding other kinds of emergencies.

Mr. McCANN: Mr. Chairman, might I ask Mr. Gunn a question with regard to subsection (a) of section 9 on page 5? Suppose that were changed so that instead of reading, "in case of an emergency affecting the health of the people" it would read, "in case of an emergency affecting the health or welfare of the people". That would be broad enough.

Mr. GUNN: That might be an advantage, Mr. Chairman. But after all, this is a health bill.

Mr. McCANN: I know. But it is a security bill.

The CHAIRMAN: Mr. Gunn, in interpreting subsection (a) of section 9—"in case of an emergency affecting the health of the people"—you would say that an emergency such as Mr. Wright mentioned undoubtedly affects the health of the people?

Mr. GUNN: Yes; undoubtedly, sir.

Dr. HEAGERTY: No.

Mr. GUNN: Crop failure would certainly result in the depreciation of living standards, and consequently inability to pay for the necessities of life, of which insurance is one. If that condition arises, the Governor in Council has to consider the situation.

Mr. COTE: Are you referring to subsection (d) of section 9?

The CHAIRMAN: Section 9, subsection (a).

Mr. COTE: Yes. But is not Mr. Gunn referring to the interpretation of subsection (d)?

Mr. GUNN: No, not (d) particularly. I think one has to read (a), first of all, and follow by reading (d) of subsection 2.

Mr. COTE: Yes.

Dr. HEAGERTY: Mr. Chairman, Mr. Gunn was kind enough to defer to me in medical matters. But now he has stated that during a depression the health of the people is affected. During the depression the health of the people was never better. If you will refer to the death rates and the general health of the people, you will find that was the case. I think it must be understood that the advisory committee on health insurance was considering health insurance only when it drew up this bill, and that it had no intention of making provision for a financial emergency such as has been mentioned. If it is the desire of this committee that a section or clause be introduced for that purpose, then by all means let it be introduced. But, personally, I do not think that it is necessary or that it is advisable inasmuch as section 6 (1) meets the needs, whatever they may be.

Hon. Mr. MACKENZIE: Section 6 (1) of the provincial act.

Mr. SLAGHT: How much would it cost the country to assume all of this \$12 levy? Has that figure been given?

Mr. MARSHALL: How much would it cost the province?

Mr. SLAGHT: No. How much would it cost the dominion if it assumed that levy?

Mr. MARSHALL: Somewhere in the neighbourhood of another \$100,000,000.

Mr. GERSHAW: Could you say what additional percentage would have to be added to the normal income tax to cover this whole amount? I am not speaking of the graduated tax, but of the normal income tax.

Mr. BRYCE: Mr. Chairman, I spoke about that earlier this morning unless I understand the honourable member to mean the normal tax as distinct from the graduated tax.

Mr. GERSHAW: Yes—the 7, 8 or 9 per cent at the present time. I want to know what the additional amount would be.

Mr. BRYCE: It would be a question of determining how much that normal tax yielded and comparing it with the \$250,000,000 cost of health insurance. That could take some computation. It is not a question of comparing it with the total of incomes in Canada, because all those below the tax exemption limits would be excluded; so that it would really be what percentage would the \$250,000,000 constitute of the incomes of people subject to income tax.

Mr. GERSHAW: Yes. That is right.

Mr. SLAGHT: That figure was \$94,000,000. That is your estimate?

Mr. BRYCE: Yes. It would be risky to guess at it, but I think you would have to almost double the normal tax. That is only a guess, though.

Hon. Mr. MACKENZIE: It would certainly be more than one-third, anyway.

Mr. BRYCE: Oh, yes.

Mr. LOCKHART: Mr. Chairman, it has been rather interesting to hear Mr. McIvor, Mr. Warren and the others, in the references that have been made, and also what Mr. Wright has said, from the viewpoint of the provinces only. There is a matter on which I would advise Mr. Warren, and would also draw to the attention of the committee. As for what Mr. McIvor said about never receding to any such condition as we had in the days following 1929, I hope that wishful thinking may eventually be justified. But I want to point out not only to Mr. Wright but to others that there are those of us who have seen families of teen age children just leaving school, with no gainful employment, where the adult father would be required or be called upon to pay \$12, in three and four instances, with a lessened income. I really draw to the attention of the committee that there are many possibilities of inability to pay the \$12 contribution. I think we should keep that in mind very definitely whether we are considering contributory payment or whether we are considering it on the particular basis on which Mr. Wright would want it considered in the matter of the provinces. I am hoping that this wishful thinking which has been indulged in here is going to come true; but we already have, in some sections, certain types of unemployment. I would point out that until extensions are made in the construction industry, we shall have that; mechanics have been out of work for two months this winter because materials are not available. I want to draw to the attention of the committee the very definite situation that may arise to a greater or lesser degree, where a burden is being imposed upon parents who have children, three and four of them, coming out of school with no means of support, perhaps where a parent has to assume not only the care of those children, but medical and other types of health facilities,—operations and that sort of thing,—when he has to make a \$12 contribution a year for those children, which will run into \$36, \$48 or sometimes \$60.

The CHAIRMAN: You would not call Mr. McIvor's optimism that of a Daniel comes to judgment, would you?

Hon. Mr. MACKENZIE: He does not pay anything for the children under sixteen.

Mr. LOCKHART: I am referring to all that has been said this morning.

Mr. BLANCHETTE: I understand that the amount that was decided on last year or the amount which was discussed, was \$26 per head, and that the present amount is \$12. Would the financial committee give us some explanation for the \$12 being taken instead of the previous \$26?

Dr. HEAGERTY: It is not a substitute for the \$26. It is the contribution of each individual. Perhaps you could answer that part of the question Mr. Marshall.

Mr. MARSHALL: I think, Mr. Chairman, there are two main reasons why the \$12 was chosen by the committee. We went over all kinds of schemes, some of them pretty wild and woolly, when we really got down to analysing them. I think the main reasons why the \$12 was chosen were these:

- (a) The committee felt it was important to choose an amount sufficiently low to be within the ability to pay of the great majority of insured adults, because (i) the more people that contribute the less likelihood of any feeling of indigency; (ii) as the collection of this part of the contribution is a provincial responsibility, a higher amount, which would

automatically bring about the greater share of the cost to be paid from general provincial revenues, might make it financially impossible for some provinces to enter into the plan.

- (b) The sum of \$12 lends itself to collection by the month or by the quarter, or other simple means.

Mr. McCANN: There is a feature of this whole scheme that I do not like and it goes to the financial end of it. It is with reference to the amounts that are paid and what you might call the double or triple taxation. Take, for instance, a man living in the city of Ottawa. There is a big civic hospital here that is being paid for and debentures are being retired yearly. Every man in his tax bill makes a contribution on his real estate and his income towards the liquidation of that debt. Then if this goes into effect, he is going to pay \$12 per year per person in his family over sixteen into the provincial treasury. Then he comes along again when he pays his income tax, and he is making another contribution. Now he very naturally asks the question, "Why cannot this all be put into one tax payment for health insurance?" Instead of that, he is paying three different taxes into three different sources for the very same thing, namely, the protection of health insurance. We should be able to evolve some scheme of taxation whereby a man, having paid one tax and made one contribution, has met the end as far as that particular problem goes. That is going to be one of the objections the general public will have to it, because we are all so tax-conscious in these days and are paying in to so many sources. As far as ability to pay from now on and after the war is concerned, with all deference to the finance committee that are advising here, I would say that they are not going to be able to estimate what the national income of this country will be and what amount can be obtained from income. So I think it is foolish at this time—at least, that is my judgment—to talk of having it all come out of income, because there is no one who can estimate what the income of either individuals or the country as a whole will be. So I think we should attempt to evolve some scheme where we will have one single payment for health insurance, and a man having paid that, will have paid his contribution for the year. I think that is a matter to which we might give some thought.

Mr. HOWDEN: Following that up, Mr. Chairman, the mere fact that he is paying a municipal levy towards a hospital would not relieve him of the expense of sickness, if he had to send a patient to the hospital. I do not think you could overcome that point at all.

The CHAIRMAN: Would you care to comment on that, Mr. Bryce?

Mr. BRYCE: Well, Mr. Chairman, as regards the municipal aspect of the problem, I am unable to comment intelligently on that, although from the way it was described it sounded very much as though it was a question of the municipality redeeming its indebtedness in respect of the hospital, which is not really current upkeep cost.

Mr. McCANN: No. It is a tax for health.

Mr. BRYCE: It is a tax related to health, but I should think that after all health insurance will make it easier, in general, to finance hospitals, so that over the long run it should reduce the extent to which municipalities have to levy taxes to meet health costs. As regards, the two contributions, that is something we considered at some length in our committee. It should be understood that they are separated primarily for administrative reasons. We went to some pains to try to devise a scheme which offered a fair chance of simple and practical administration. Therefore we have tried to arrange that, wherever it was necessary formally to base the contribution on income, it should be done through the existing income tax machinery. It would then obviate the necessity of the citizen making several declarations of his income, filling out

several of the forms which we are all conscious of and which cause us some considerable pain and trouble in preparation as well as in payment. The other portion, the \$12 payment, was intended to be collected locally, in close relation to the administration of the Health Insurance Act itself, as Mr. Marshall has explained, enabling the records of the insurance scheme itself to be kept fairly clear and related directly to the contributions made. That is the basic reason for the division of what is otherwise essentially one payment. That is to say, it is a payment which commences, let us say, at zero for the man unable to pay anything because it would be wholly abated in his case. It will rise according to the severity of the province in judging the ability of the person to pay his \$12 contribution. It is presumable, let us say, for the majority of individuals below the income tax level, that the payment will be a standard payment of \$12. When you come up to the income tax exemption level, the payment then begins to increase and runs on up to the specified maximum of \$42 in the case of single people and \$74 for married persons. That is to say, we have not a payment that is based purely and directly on ability to pay, but it is a payment which constitutes, I would say, a reasonable and simple compromise between the ability-to-pay principle, the insurance principle and the practicability of administration. All these considerations had to be taken into account. In our interim report, which I understand was provided to the committee, we did deal with this question of the separation of the two contributions. I can read the applicable portion of that, if you wish.

The CHAIRMAN: Yes. I think it would be helpful if you did.

Mr. BRYCE: Very well. It reads as follows:

The argument has been made to us that there should not be two contributions for health insurance, i.e. a fixed fee one of \$12 plus a contribution based on income. It is said the public will regard this as duplication and object to it. It is obvious that there would be many people who would like to get health insurance for as little as possible. Nevertheless it should be practicable to make clear that the \$12 is merely the minimum that must be paid as a general rule, the first instalment, so to speak, and that the income contribution is the balance of the contribution which is paid by all who are able to pay it and is calculated to take into account their ability to pay. To use only the \$12 amount would not make the scheme sufficiently contributory in our view, especially for those who can afford to pay substantially more and who are, in fact, paying substantially more for the medical services that they are now receiving privately and will receive as part of the insurance plan. We do not believe it would be desirable to delude the public into thinking that health insurance is not costly. It involves very heavy burdens and the public should realize that it is getting valuable services that are worth paying for. To attempt to avoid the appearance of two contributions by starting from the other end and fixing a higher standard contribution and then abating it in all cases where incomes are less than a specific figure is equivalent to the scheme originally proposed and leads inevitably into great difficulty in assessing all incomes below the income tax level. It would not be so difficult if only wage earnings were involved, although that does present very grave difficulties for all employers. As we have seen, however, in considering the original proposals, it is extremely troublesome and costly for the great numbers of those with low incomes obtained from other than wage earnings. In many of these cases the amount actually collected would be quite small in relation to the costs of collection.

Mr. McCANN: What about the objection of paying it into two or three different channels? How are you going to appease the public mind in that regard, and show that it is not a duplication of taxes when he is actually paying into two or, in some instances, three different channels?

Mr. BRYCE: I would say that would require some explanation to the public to the effect that they pay it through two different channels because the one channel is already collecting a contribution, a tax, based upon their incomes, and it will save the public trouble if they pay their income portion of the Health Insurance contribution through that channel; and secondly, that the other part of the contribution is paid directly to the health insurance authorities, presumably as a condition of registration, in getting their necessary documents to entitle them to health services. It will undoubtedly take some explanation, but I think there is a reasonable explanation which can be given.

Mrs. CASSELMAN: Mr. Chairman, I wonder if they have computed the amount that would be necessary if the same principle held above the \$660 and the \$1,200 amount. Below that you have charged 2 per cent or around 2 per cent. Above that it is 3 per cent. Why should that go up immediately there? What I should like to see would be a lesser charge on those people of moderate income, so that the \$74 would be attained at a higher level of income rather than at around \$2,200. I wonder if any calculation has been made there.

The CHAIRMAN: Could you answer that, Mr. Marshall or Mr. Bryce?

Mr. MARSHALL: I am sorry, but did I understand Mrs. Casselman to say we had recommended 2 per cent below the income tax level?

Mrs. CASSELMAN: It is around there.

Mr. MARSHALL: I do not think our committee has suggested any amount to be paid below the income tax levels.

Mrs. CASSELMAN: No, but it is 2 per cent. \$12 is around 2 per cent on \$660 and \$24 is around 2 per cent on \$2,000.

Mr. MARSHALL: Yes.

Mrs. CASSELMAN: As soon as you reach that level you are going up to 3 per cent. It seems to me that a great many people in this moderate income bracket above \$660 for single people and above \$1,200 for married people, will need to have a great deal of consideration in order to pay their health insurance tax.

Mr. MARSHALL: Maybe I could answer that question in this way, by answering the question "Why were 3 per cent and 5 per cent rates and maxima of \$30 and \$50 chosen?" Largely because, in the committee's opinion, they were not unreasonable rates or amounts to pay for the freedom from fear of the financial burden which might be placed on a person by reason of a severe illness of such person or his dependants during the lifetime period.

For instance, a single person who would pay at the maximum \$42 per year might quite possibly have a severe illness in a ten-year period which would, under present conditions, cost for doctor's fees, nursing service, hospital care and medicine \$500. Similarly, a married person who would pay—if at the maximum—\$74 in the same time, might have illness which cost more than the amount contributed in a ten-year period.

The majority of us now who are in modest circumstances have a fear that we may be faced with illness which will place us heavily in debt, or among older persons that such sickness may even use up savings accumulated in a lifetime. Surely it is worth something to have such a fear removed. On the other hand you could start, say, at 2 and 4 per cent and go up higher to your maximum so you would reach into the higher levels of income, but you would not get so much money in that way. Then you might even cut off at, say, the maximum of 30 and 50—a maximum of 20 and 40—that would mean that the dominion

would have to assume more than its \$100,000,000 estimated contribution. There are all these ways that can be put in, but the reason the committee shows this is from the statement I made just now.

Mr. MACINNIS: Whatever system we adopt, a great deal of education will be necessary. It is not necessarily paying over something in addition to what you are already paying because that will be deducted from your medical and dental expenses. As far as medical services are concerned, it varies quite a bit, but very few individuals, I think, can get away with medical and dental services each year for \$12, or the amount that would be added to that \$12 or 3 or 5 per cent. I think if that were made clear a family would not feel they were paying \$74 in addition to what they are paying now. They are paying that \$74 in lieu of whatever they spent in medical and dental services.

Hon. Mr. MACKENZIE: That is very important.

Mr. ADAMSON: That question that Dr. McCann brought up is mentioned in the Ontario bill. I understand under the provisions of that bill the municipalities have a right to withdraw from the scheme after a three-year trial period.

Mr. GERSHAW: I was going to ask what is proposed to be given up to 16 years of age in the way of dental treatment, because dentists cannot handle them at present. There is another question with regard to the \$100,000,000 contribution by the dominion which looks after children up to 16 years. The statisticians here offered at the last meeting to find out how much additional would be required to pay for people between the ages of 16 and 21 who are not earning money—they may be attending university. I wonder if I could find out what additional amount that would be?

Mr. MARSHALL: I hoped to have that information available this morning from the 1941 census, but unfortunately it required the tabulation of some 2,500,000 cards. Those are going through the tabulators now and we will have that information for the Committee as soon as possible.

Mrs. CASSELMAN: This is going to bear pretty heavy on those people with moderate incomes. I think the average is \$21.60 per person. That \$43 is considerably over that and \$74 is considerably over the \$43, which would be the average cost. I think it is too heavy on these people of moderate incomes. I would like to see real consideration given to a suggestion that that 2 per cent be continued beyond the minimum of \$660 and \$1,200, and then the higher incomes would reach \$74. It seems to me that these people of moderate income are the people who are most careful of their health, who obey health rules and do not have as much illness as, perhaps, the very rich or the very poor, but it seems to me that they are the people who are going to pay too much for this health service.

Dr. HEAGERTY: Mr. Chairman, probably you will remember that the Gallup poll some years ago made an investigation inquiring into the views of the people with regard to health insurance. They put their question in a rather peculiar way. They asked: Would you be willing to pay about \$1 a month for health insurance? I did not like the way that question was put; but 70 or more per cent of the people replied, Yes. So I think we know that in so far as the \$12 is concerned the people will be satisfied to pay that amount. That is the amount that is set down here.

When agriculture presented its views to this committee it suggested that the entire cost should be paid out of the national revenues of the country. There is a rising opposition to health insurance—I do not know whether you are familiar with it—with regard to the payment of 3 and 5 per cent income tax—that is to say the payment of an amount in addition to the \$12—the dual payment that was mentioned by Dr. McCann. The people do not like it.

They won't like it. And they are objecting to it very vociferously. I know what they have in mind; they do not want a dual payment. If it were possible to obtain \$1 a month from every individual and obtain the rest of the money from the national revenues I believe every family in the country would be satisfied. I feel that labour would be satisfied. Labour would like a contribution from industry, but it is felt that it would be injurious to industry to ask any such contribution. I would like this committee to take into consideration the contribution of \$1 a month or \$12 a year from each person and the payment of the balance from the national revenues of the country, if it is possible to collect the costs in such a manner.

Mr. Bryce in making his report stated that it had been called to their attention that there might be some objection to this dual method of payment. As a matter of fact, it was I who brought this to their attention, because as a doctor I knew that it happens to be bad psychology. One payment is sufficient. If we wish to increase the \$12, well and good, but I do think that one payment by the people of Canada is enough, and that the balance should be paid from the national revenues of the country.

Mr. McCANN: Dr. Heagerty, would it not be possible if that scheme were put into effect with one payment and the rest from a national contribution to still have it come from an increased general rate in income tax but not specifically labelled for health insurance? I think that the same objective could be obtained if the income tax could be increased to the extent that that \$50,000,000 would be brought in, but it is not specifically earmarked on a tax bill as going for health insurance. The ultimate end would be exactly the same, but it would do away, in my judgment, with a considerable amount of the objection that is going to come from people in the income tax levels who have to pay the amount. I do not think you are going to have as much objection from the class of people sometimes called the middle class—if we have any classes in this country. I have practised medicine for thirty-five years and I know people intimately, and I know that the people we may call the working class make by long odds the best clientele that any doctor can have. For that reason I think they probably have more sickness in their families and they are the best pay a doctor can have. When you can show to these people that this is just a substitution of the amounts of money which they have been in the habit of paying yearly into a sick fund they are not going to be the people who will raise any objection to this, and the people who are not in that income level are going to be taken care of by the province. So the great bulk of the people, 94 per cent of them, are in the income class of about \$2,200 or \$2,300 at least, and they are not going to object because they are the people who heretofore have consistently met their medical and hospitalization bills.

Dr. HEAGERTY: The objection arises chiefly from the young industrial workers—the stenographers, the clerks, and others who say: I am not sick; why should I pay this amount; why should I pay twice for one service? The objection is coming to a very large extent from the cities.

Mr. BRUCE: Mr. Chairman, Dr. Heagerty quoted the result of a Gallup poll a few moments ago and I would like to ask if he thinks that is a reliable way of estimating public opinion?

Dr. HEAGERTY: It is generally accepted as a fairly good method of ascertaining what way the wind blows.

Hon. Mr. MACKENZIE: It is a straw vote.

Mr. WATSON: Mr. Chairman, the question of taxation and of double taxation has been discussed. Maybe an explanation of the health insurance measure would help to an understanding of it. I think it is very important that one point should be made clear, and it is this, that so long as nobody is required to pay

under the guise of a health insurance contribution more than is necessary on the average for adults to pay to finance health insurance, the contribution is not a tax. I think we should dismiss from our minds the idea that it is a tax, provided that that amount is not exceeded. We may abate the contribution whether through income tax machinery or in any other way. If we abate the contribution, having regard to the economic standard of the individual or the family group we are not burdening that individual or family unreasonably. If we are prepared in the case of hard circumstances in any particular year to abate according to the circumstances of such years, then there would be no tax for health insurance. I wish to make that point clear. If we were supplying milk to the people in Ontario or to the people of the city of Ottawa, and not charging the individual more than the market price of that milk, furnished through government machinery, we will certainly not be taxing anybody, and if we were to reduce the cost to half or a quarter or a third for the people who happen to be poor, I submit that we will not be taxing these people. The taxpayer would be called upon to help these poor people pay for their milk. It seems to me it is the same for health insurance. If we fix upon a reasonable health insurance contribution and the people above a certain standard pay that in full, and below that we make abatements if necessary, depending on the circumstances from year to year, then nobody will be taxed, and we will be collecting from the Canadian taxpayer taxes which will find their way into the abatements that will be made in the contributions of the poorer people.

Mr. HOWDEN: With regard to the suggestion made by Dr. Heagerty that we take the \$12 levy and that the balance of payment be made out of the general revenue fund, we must remember that the general revenue fund represents the truest taxation of the citizens of the country. The general revenue fund is the accrued taxes that nobody escapes. Whether a man is only making \$600 or not he pays to that general revenue fund, and it seems to be eminently fair that the excess over the \$12 level should be paid out of the general revenue fund. I would like to ask Mr. Watson what he has to say about that?

Mr. WATSON: Twelve dollars is a low contribution. My notion is that the contribution for health insurance should be such a uniform per capita contribution as would be sufficient to provide health services for the people entering industry from the schools and universities year by year. The per capita contribution would be sufficient to carry them on the average through life, to provide health services for themselves and for their dependent children. That would be the per capita cost. Certainly \$12 would not meet that. It does not seem of fundamental importance whether that contribution is all collected by the same machinery or not, although some of us may have a preference for collection by one piece of machinery; but I think it is probably important that there should not be a specified health insurance tax anywhere. As a member mentioned a few moments ago, it is probably wiser to have any such taxes collected in a general way rather than as a special tax. I believe that special taxes are rather in disfavour among taxation authorities, and there is no particular benefit to be derived by having a special tax so long as we do not tax under health insurance. There can be no question of double taxation.

Mr. HOWDEN: There is no great objection to having the balance come out of the general revenue fund at that rate?

Mr. WATSON: The balance over \$12?

Mr. HOWDEN: Yes.

Mr. WATSON: I suggest it is taking a great deal from the general revenue fund; and in addition I do not know of any real good reason why the individual or the family group who are in circumstances able to pay should not pay the full contribution, or substantially so, and in addition the general taxpayer would

help the poorer people to pay the abatements in their health insurance contributions. After all, the main purpose of health insurance is to enable people to ensure themselves against the devastating hazards of ill health, operations and hospitalization which cannot be foreseen, by paying uniform contributions. Now, if people are well able to pay the full contribution, I do not see any reason why they should not pay, and also as taxpayers help the poor people. That is exactly what we do now with reference to nearly everything. It seems to me that as far as adults are concerned, unless there are social reasons for making abatements, they should pay approximately the full amount, and I do not object to the full contribution, and any addition which they are able to pay as taxpayers they contribute as taxpayers to help the poorer people.

Mr. HOWDEN: I take it that Mr. Watson is referring to the full contribution of \$12, and it is not suggested that anybody pay less than \$12 if they are able to do so. But the point I would like to get fully threshed out is this; are not those people who are paying—those well-to-do people, let us say—paying proportionately into the general revenue fund in the matter of their payments, and would they not be paying proportionately according to their wealth for the coverage of this health insurance after paying the original contribution if the balance were taken out of the general revenue fund?

Mr. WATSON: In referring to the contribution I was not referring to the \$12 alone; I was referring to the total that might be necessary to levy on adults to cover the whole cost of health insurance. That is what I meant by contribution. Under the proposal we now have there is a \$12 contribution and there is another contribution collected through income tax machinery which has been referred to as a tax. Now, there may be some tax in it, I do not know. I do not think there can be any objection to two contributions provided that it added together do not result in taxation. The sum ought not to exceed the full annual contribution, and if the circumstances of the individual are not good enough there would be abatements in the contribution. Any taxation that may be necessary to finance those abatements ought to be taken care of, I think, out of the general taxation of the dominion government and of the provinces.

Mr. McCANN: You mean that on the income tax return it is not going to be referred to as a contribution; it is going to be referred to as income tax?

Mr. WATSON: It is referred to as a contribution, as a health insurance contribution, and it may be necessary, as has been suggested, that a great deal of explanation should be made to make that point clear.

Mr. HOWDEN: Does not a person pay anyway whether he pays it as a second contribution or out of the general revenue fund?

Mr. WATSON: I do not think so. The insurance contribution is related necessarily to insurance benefits.

Mr. HOWDEN: If it is to be paid out of the general revenue fund he pays his share of it?

Mr. WATSON: He will pay his share, but a different share from the health insurance contribution. Take the case of the supply of milk. There must be pretty close connection between the amount of milk that is consumed by the poorer people and the richer people. There may not be any wide difference, and the same is true with reference to health insurance services: the amount consumed by the poorer people will not differ very widely from that consumed by the richer people. Consequently, the insurance contribution should be the same and uniform, but as many people will not be reasonably able to pay the contribution some provision must be made for abating in their case; and if a proper scheme of abatements is worked out it will be in harmony with sound insurance principles; it is simply the waiver of contribution in circumstances

where the individual may not reasonably be able to pay. It is like the waiver of the life insurance premium where the individual has happened to fall into a state of ill health and cannot reasonably pay his premium.

Mr. MAYHEW: Now, with regard to this \$12 I understand it is estimated that you will get about \$94,000,000 a year, and I wonder what it is going to cost us to collect that \$94,000,000. It seems to me that you will be setting up all over Canada committees of investigation, hearing applications from people who want to evade paying that \$12, and the collection cost will be considerable in doing that. I do not think you are going to get as much benefit out of the \$12 as is proposed. With regard to this matter of \$1 a month, it is very easy to say that it is \$1 a month but it does not mean \$1 a month; it means at least \$24 a year, \$2 a month to a married man. If he is a married man with children going to college just at that time and he needs money the cost is probably \$48, and he has previously paid a certain amount towards it in his income tax. I want to specifically mention the fact that you are not going to get \$94,000,000 a year out of it; you have not deducted your expenses of collection.

Mr. BRYCE: I think it is quite correct that there will be some cost of collection, particularly in those instances where there is a partial abatement. That is one reason why we suggest that it should be handled by the provinces and should be tied in with the local administration of health insurance; because then the local officers can help look after this matter and that will help to keep down the cost of collection. I think it is inevitable that you have some costs of collection of your contribution. We had in mind attempting to get that cost down to the lowest practicable limit. You cannot possibly determine whether or not a person is able to pay a contribution without incurring some cost in doing so; and it is a question of reconciling justice and equity as between individuals with the cost of achieving justice and equity.

Mr. MAYHEW: There is not only the cost of collection to be considered but the cost of investigation as well.

Mr. BRYCE: Yes.

Mr. JOHNSTON: Having regard to collection, could you not forewarn the provinces to be prepared, when they come down here, to give you some sort of estimate of what their administration costs will be? I think you might find that the administrative costs of the provinces and the dominion are going to be such that it might be cheaper to take this from another angle. In the case of Alberta, I understand that they are now giving free hospitalization to all maternity cases. The point was argued quite strongly that this service should be given only to those under a certain income level; but after careful investigation they found that the cost of administration of carrying on such a thing as that, to determine what their income is, and what the cost would be if they divided it, was such that it was cheaper to take it out of the general taxation than it was to do it on a contributory basis. I am afraid you will find there will be the same thing here. I think it is generally admitted that if, after the last war, we had given the returned soldiers their land outright, we would have been money ahead, when we consider the tremendous cost of administration. I think you are going to find the same thing here.

The CHAIRMAN: It is now 1 o'clock.

Mr. MACINNIS: Before we adjourn, Mr. Chairman, may I ask for some information for our next meeting?

The CHAIRMAN: Yes.

Mr. MACINNIS: Perhaps it is not available. I was wondering if there was any information available in the Department of Pensions and National Health,

or where the finance committee could get access to it, of the medical service societies now in existence. There are any number of them, I know; I belonged to one of them at one time. I should like to have information as to what monthly contributions members pay, what services they get for those contributions and what services they would receive under the proposed Act.

The CHAIRMAN: I am informed that information will be provided.

Mr. MACINNIS: I think it would be very useful.

The CHAIRMAN: We will continue the discussion of the financial structure at the next meeting.

The committee adjourned at 1.05 p.m. to meet again at the call of the chair.

CAL XE 2

SESSION 1944

-43571

HOUSE OF COMMONS

SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 4

WEDNESDAY, MARCH 22, 1944

WITNESSES:

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. A. D. Watson, Chief Actuary, Department of Insurance.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



MINUTES OF PROCEEDINGS

WEDNESDAY, March 22nd, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs., Adamson, Blanchette, Breithaupt, Bruce, Casselman (*Mrs.*), Claxton, Cleaver, Coté, Donnelly, Fulford, Gershaw, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Leclerc, MacInnis, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McIvor, Slaght, Veniot, Warren, Wood and Wright.—27

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. J. T. Marshall, Chief Vital Statistics, Dominion Bureau of Statistics;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;

Mr. J. F. Howes, Research Staff, Bank of Canada;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health.

Mr. Hurtubise recommended that crippled adults should be taken care of under the Health Insurance Bill. The Chairman said this matter could be dealt with when each clause of the Bill is under consideration.

Dr. Heagerty, Mr. Bryce and Mr. Watson were called and examined.

Mr. Coté moved: "That the alternate plan (b) be adopted".

The said plan reads as follows:—

"Retaining the amount of \$12.00, abolishing collection by means of income tax, and supplementary payment through the national revenue in lieu thereof."

Mr. Howden moved in amendment thereto:—

"That the flat rate be \$10.00 per head."

Discussion followed and the Chairman announced that Mr. Coté's motion and the amendment thereto would be considered at the next meeting.

Hon. Mr. Mackenzie replied to a question asked by Mr. Gershaw on page 46 of the evidence respecting the additional cost of providing for children from 16 to 21 years of age.

The witnesses retired.

On motion of Mr. MacInnis the Committee adjourned at 1.10 o'clock, p.m. to meet again at the call of the Chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS, March 22, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. The Chairman, the Hon. Cyrus Macmillan, presided.

Mr. HURTUBISE: Mr. Chairman, you probably have the agenda for today. Before you proceed with that agenda, I should like to bring a question before the committee for consideration. As I see it, when this bill goes through, it is going to be all-embracing and will probably take in all of the preceding legislation such as old age pensions, mothers' allowances and different things. On page 10 of the draft bill, the first schedule, section 3, I see reference to crippled children. I suppose it means crippled children up to the age of 16. There is, however, another class of people to be considered. I should like to ask Dr. Heagerty if this group of persons has been considered in the elaboration of the program, namely crippled people in general. It is true that the old age pension takes care of some of those and the workmen's compensation takes care of others. The proposed legislation will take care of crippled children up to a certain age only. Year in and year out I have people coming to my office from that age up to the old age pension age who are handicapped in life. Some have even gone through special courses of study, such as accounting and so on, in order to become specialists, but they cannot find any work whereby to make a living because they are handicapped. It is only those with kind hearts who will help them by employing them. I wonder if Dr. Heagerty, in his elaboration of this program, has considered this subject. These people are really handicapped, and there are many of them in the world who are suffering in this way and are not able to get jobs. I hope consideration will be given to them and that they will be helped in some way.

Dr. HEAGERTY: We did not take adults into consideration. We had in mind only the children. We were dealing with the problem only from the standpoint of the prevention and treatment of crippling conditions in children. We felt that something definite should be done both by the provincial authorities and by the Dominion authorities to assist in the prevention of crippling conditions and in their treatment. That is all that we had in mind. We know that very little has been done in the way of prevention in Canada. In some of the provinces active steps are taken to reduce the incidence of infectious diseases, but in others the measures are not so complete because of lack of funds. The crippling conditions we had in mind were chiefly the results of infantile paralysis.

Mr. HURTUBISE: There are many others.

Dr. HEAGERTY: And heart conditions and arthritis. We believed that something should be done for those children, as I have said, both in the way of prevention and of treatment. That would not confine the program to those two fields, but might take in as well the question of education and the finding of positions. I am glad, however, that you raised the question of crippling conditions among adults, because in some industries, as you know, provision is made for engaging crippling persons. There are many in the government service, for example. A large number—I cannot say the exact percentage—of crippled persons are employed by the Ford Company. Following the last war, in Germany provision was made by law that every company was obliged to engage 2 per cent of crippled persons. It is therefore apparent that the entire question is one of very

great importance, and I am very glad indeed that it was raised. But I think if we make a beginning with the prevention and treatment of crippling conditions in children, we shall have taken a step forward.

Mr. HURTUBISE: But Dr. Heagerty, you have presently legislation in preparation which is all-embracing, covering old age pensions, mothers' allowances under certain conditions. But the crippled children, which you have just mentioned, will constitute only a certain percentage of this class to which I refer. What about the 90 per cent who are left over and are not being taken care of? Even after making sacrifices in order to specialize in certain lines, or taking special courses, they are still left on the rocks, rambling around and trying to get a start of some kind which they cannot get. I hope that this problem will be given sufficient consideration. I am referring to crippled adults, and not children. That does not mean only those crippled from disease. There are many accidents which do not come under workmens' compensation. I have many of these cases coming to me. I say that there is the old age pension, there is the mother's allowance, and there is other legislation; but as far as crippled adults are concerned, there is no legislation. Their only help is from the municipalities, either through the provision of suitable jobs or relief.

The CHAIRMAN: When the sections of the bill are under discussion, section by section, this problem can then be discussed. We will ask you to make certain representations to the committee in support of your contention, Mr. Hurtubise. Will that be satisfactory?

Mr. HURTUBISE: When is that?

The CHAIRMAN: When the clauses of the bill are under discussion, section by section.

Mr. HURTUBISE: I just wanted to bring this to your attention, in case it would not be considered.

The CHAIRMAN: Thank you very much.

Mr. COTÉ: It is a good point and one which gives us food for thought, Dr. Hurtubise.

The CHAIRMAN: Dr. Heagerty, will you present this agenda?

Dr. HEAGERTY: Mr. Chairman and gentlemen, at the last meeting there was a considerable amount of discussion regarding the collection of contributions, and it was suggested at that meeting that contributions might be made by means of a direct levy of \$12 and a tax of 3 per cent for single persons and 5 per cent for married persons. The discussion would indicate that there was some doubt as to whether or not the collection of the contributions in that manner was equitable. I thought in order to expedite the proceedings that I would place before you a brief agenda setting forth the method of providing funds indicated at the last meeting, and some alternative methods for discussion; because I believe it is extremely important that we should arrive at some conclusion in regard to the question of both costs and the collection of premiums before we enter into a detailed discussion of the entire bill.

At a previous meeting, as you will remember, it was suggested that there should be a conference with the provinces and it was recommended in your fourth report that the advisory committee on health insurance should proceed to the provinces to discuss the entire question of health insurance and to explain to the provincial authorities the report of the advisory committee and the proposals contained therein. The committee did not feel that it was competent to proceed to the provinces to make any proposals to them because this committee had not arrived at any definite conclusion in regard to either costs or contributions. We felt, as a committee, that it would be very unwise for us to proceed to the provinces unless we had some specific proposal to place before them. We are in pretty much the same position at the present

time. We have placed before you an alternate proposal. It may be one perhaps of a number. But until some decision is arrived at in regard to the proposals, we do not feel that we should have a conference with the provinces. We are not really in a position to do so. Nevertheless, as you know, this plan is so broad, so big in every way, that it does not appear to me that the dominion alone can establish a health insurance plan covering the whole country. It is essential that there should be a discussion with the provinces. I think perhaps all of you are pretty much in agreement in regard to that. This plan intimately affects the provinces in quite a number of ways, and therefore the provinces, I think, should be consulted before any definite and final steps are taken. In any event, we should have some clear ideas in mind before we discuss it, and therefore the advisory committee on health insurance is anxious to obtain the views, even though they are not final, of this committee, before any such discussion takes place. It is for that reason that I place this brief agenda before you.

At the last meeting you will recall, that Mr. Johnston asked for some information in regard to voluntary medical organizations. I have prepared a brief memorandum covering some of the Canadian organizations which are better known, and a few of the American, for your consideration. This is only a very brief summary. It covers a small number only of organizations. If you require a greater number, we can obtain that information for you. I might point out that there is a great variety of these organizations that are of a voluntary character, but not one of them is complete, as we understand health insurance. So that I do not think it is necessary to go into the question in much greater detail than is done in the memorandum that has been placed before you, but additional information will be available if you desire it.

The CHAIRMAN: Will you give the committee those figures, Dr. Heagerty?

Dr. HEAGERTY: As to the medical service organizations?

The CHAIRMAN: Yes.

Dr. HEAGERTY: A copy has been provided for each member.

The CHAIRMAN: Give one to the reporter.

Dr. HEAGERTY: I will read this memorandum. There is Medical Services, Vancouver, B.C.—

Mr. DONNELLY: Is that the organization in Vancouver?

Dr. HEAGERTY: Yes; then there is Associated Medical Services, Inc. and Hollinger Employees' Medical Services. They are the three I have put down here, because they are the best known organizations.

Mr. DONNELLY: Can you give us some of the details, such as how many doctors and so on there are in these organizations?

Dr. HEAGERTY: I have not all of the details. I have the detail only respecting the costs and services that are provided, and not as to the number of doctors, because these are voluntary organizations and pay their doctors on a fee basis. Therefore all the doctors in Vancouver might be included.

Mr. HOWDEN: We have not a copy of this memorandum, Mr. Chairman.

Mr. COTÉ: We received it by mail.

Mr. MACINNIS: Dr. Heagerty, where is Associated Medical Services, Inc. located?

Dr. HEAGERTY: There is one locally in Ottawa. There is one in Toronto. There is also one in Windsor.

Mr. MACINNIS: Is there one in Vancouver too?

Dr. HEAGERTY: Yes. There is Medical Services, Vancouver, B. C.

Mr. MACINNIS: You have here, "Medical Services, Vancouver, B.C." and you have "Associated Medical Services, Inc."

Dr. HEAGERTY: Yes. It is a different organization.

Mr. JOHNSTON: Is that in Vancouver?

Dr. HEAGERTY: No. Associated Medical Services have offices in Toronto, and in Ottawa. In Windsor is the Windsor Medical Services Inc., I believe.

Mr. MACINNIS: That is what I wanted.

Mr. BREITHAUPT: Do you know what other cities have Medical Services? Does the number include Kitchener?

Dr. HEAGERTY: There are a number. Associated Medical Services has been extending its branches. What cities they cover at the present time I cannot tell you.

Mr. DONNELLY: Have they very many members or does it operate to any great extent?

Dr. HEAGERTY: Yes. There are quite a number of members. I have a file here on Associated Medical Services. It would take me some time to hunt through this file for the information.

Mr. COTÉ: Are Medical Services in Vancouver operating distinctly apart from Associated Medical Services?

Dr. HEAGERTY: I believe so.

Mr. COTÉ: There is no connection at all between the two?

Dr. HEAGERTY: I believe not.

Mr. WOOD: You would not consider that Associated Medical Services cover what this health plan proposes to cover?

Dr. HEAGERTY: No. If you have read the memorandum—

Mr. WOOD: I have. But I thought it should be on record that this does not cover what is proposed here.

Mr. MACINNIS: I wonder if I could say a word, because I was the one who asked for this information the other day.

The CHAIRMAN: Yes.

Mr. MACINNIS: I do not know whether the rest of you have received any letters from persons who are members of medical associations or health service associations, but I have received a number—possibly half a dozen or so. I have one here from those in an employees' group insurance scheme in or near Toronto, the employees of the Wickham Company. There is life insurance there and there is medical attendance also. I am sure one of our difficulties will be that groups having insurance of their own, where there are a number of select contributors with, as far as I can find, a limited service, they will compare that select group with the limited service with the overall service that we intend to give under the Health Insurance Act; and as usually happens, I think they will form resistance groups to the national scheme. I think it is very important that we should have information on that, and make quite clear to these groups, and also to the public at large, the limitations, if these limitations exist, if the service is provided by groups. Also the fact must be made clear while in that case I know they are select contributors if it is in an industry, that when the employee leaves that industry, he is no longer covered. They are not covered as will be shown here, for a number of ailments and diseases, although they would be covered in a proper health insurance plan.

Mrs. CASSELMAN: In addition to that, may I just indicate, as far as Associated Medical Services are concerned, the cost for a family of two; I am paying \$48 for myself and my daughter, so there will be \$3 each on that. Then again, when we apply for Associated Medical Services, we have to state what illnesses we had, and those were excluded in the promises made for payment or part-payment. That is, the very areas where we might expect difficulties to

occur again were the areas that were not provided for by Associated Medical Services. That is, it is a much restricted area of service they are giving to the individual, according to the health previous to the time of application. I believe they also make a limit as to age, whereby they do not accept applications over 55, I think it is.

Mr MACINNIS: That is right, according to the information here.

Mr. McIVOR: I think this question was covered the other day when I asked the question about Christian Science. They have their way of looking after things, and if it will include them they will have to contribute and pay part of this scheme. Then I think everybody else will be in it.

Mr. MACINNIS: This is not for the purpose of excluding anybody.

The CHAIRMAN: No. Proceed, Dr. Heagerty, if you please.

Dr. HEAGERTY: Shall I read the whole report?

The CHAIRMAN: Yes, if you please.

Dr. HEAGERTY: Very well.

MEDICAL SERVICE ORGANIZATIONS IN CANADA

	Medical Services, Vancouver, B.C.	Associated Medical Services, Inc.	Hollinger Employees' Medical Services Assoc.
PREMIUMS PER ANNUM:			
Single Person.....	\$ 18.00	\$ 24.00	\$22.75 plus 50c. for first visit. The Mine contributes \$1.00 per employee for each period (4 weeks). Total \$35.75.
Family of Two.....	\$ 36.00	\$ 45.00	\$34.45 plus \$1.00 for each first visit. The Mine contributes \$1.00 per employee for each period (4 weeks). Total \$47.45.
Family of Three.....	\$ 54.00	\$ 63.00	Same as above.
Family of Four.....	\$ 72.00	\$ 78.00	" "
Family of Five.....	\$ 90.00	\$ 90.00	" "
Family of Six.....	\$108.00	\$102.00	" "
Family of Seven.....	\$126.00	\$114.00	" "
INSURED PERSONS.....	All under 65 years of age.	Any person under 55 years of age.	No limit as to age—employee of Mine and family.

Mr. MACINNIS: I think it should be noted there that there is a limit on the age of persons taken into the employment of the Hollinger Mine. If I understand it properly, it is the age of 35, and there is a very strict medical examination before they come in.

Dr. HEAGERTY: That is right.

The CHAIRMAN: Is there a retiring age, Mr. MacInnis?

Mr. MACINNIS: I do not know.

Dr. HEAGERTY: Continuing:

	Medical Services, Vancouver, B.C.	Associated Medical Services, Inc.	Hollinger Employees' Medical Services Assoc.
INCOME LIMIT.....	Upper limit \$2,400.00....	No limit.....	No limit.
EXAM. ON ADMISSION.....	Not at present.....	No. Pre-existing conditions excluded.	Employee for employment.

Mrs. CASSELMAN: That is not exactly right. There is an examination, according to age, for the Medical Services. There is no examination for children. It is according to age for others.

Mr. CLEAVER: Fifty-five is the age.

Mrs. CASSELMAN: No. Under 55 there is also an examination. I have forgotten what it was.

Dr. HEAGERTY: Associated Medical Services require that a certain amount of information shall be provided them in regard to pre-existing medical conditions, and of the present physical condition, but I do note that there is an actual physical examination required.

Mrs. CASSELMAN: I think so, according to the age of the person.

Dr. HEAGERTY: Possibly there is. Continuing:

—	Medical Services, Vancouver, B.C.	Associated Medical Services, Inc.	Hollinger Employees' Medical Services Assoc.
DEPENDANTS.....	All under 18 years. Limit 65 years.	Husband, wife (not gain- fully employed), son or daughter under 17 years.	No age limit. Med. exam. to be basis of admission.
WAITING PERIOD FOR SERVICES	None except obstetrics and accidents.	Two months.....	None.
OBSTETRICS.....	No service for first 10 months.	Service after midnight of the first day of the month following ten full months after In Force Date.	No waiting.
HOSPITALIZATION.....	Ward-bed 3 weeks for one illness. Conditions existing at time of en- rolment are excluded.	Semi-private not exceed- ing \$3.00 per day. Time limit in hospital left to decision of the Cor- poration. In uncom- plicated cases of ap- pendicitis and obste- trics time limit not to exceed 11 days.	Ward-bed. No waiting.
NURSES.....	As required. Hospital board not included.	No nursing except visit- ing nurses at the home at the sanction of the Corporation.	As required. Hospital board included.
ACCIDENTS OUTSIDE OF COM- PENSATION BOARD.	For first six months, Association liable for \$50 only.	Covered.....	Covered.
LIMITATION OF AMOUNT OF SERVICES IN ONE YEAR.	\$500.00	\$800.00	None.
MEDICAL SERVICES.....	Limited services.....	Limited services.....	Limited services.
CANCER, NEW GROWTHS.....	Yes, limited.....	Not if diagnosed within six months.	Yes.
SURGICAL SERVICES.....	All necessary services excluding pre-existing conditions present on enrolment.	All necessary services excluding treatment of conditions not detri- mental to bodily health and excluding pre-ex- isting conditions pre- sent on enrolment. No tonsil operation for 12 months.	Everything.
EXCLUSIONS:			
Repairs from previous childbirths.	Not included.....	Not included.....	Included.
Venereal Diseases.....	" "	" "	Not included.
Alcohol.....	" "	" "	" "
Narcotics.....	" "	" "	" "
Arising from Riots.....	" "	" "	" "

	Medical Services, Vancouver, B.C.	Associated Medical Services, Inc.	Hollinger Employees' Medical Services Assoc.
EXCLUSIONS—<i>Conc.</i>			
Civil Commotion.....	Not included.....	Not included.....	Not included.....
War.....	" "	" "	" "
T.B. hospitalization.....	" "	" "	" "
Compensation Cases.....	" "	" "	" "
Mental Disorders after diag- nosis.	" "	" "	" "
Congenital Defects.....	" "	" "	Included
Refractions, Eye.....	" "	" "	"
Eye Glasses and other ap- pliances.	" "	" "	Not included
Dentistry.....	" "	" "	" "
Drugs and Medicines in hospitals.	Yes, with limit..... No sera No vaccines No liquors No gland products, etc.	Yes, with limit.....	Yes.
Drugs and Medicines out- side hospitals.	Not included.....	Not included.....	Not included.
Dental X-rays.....	" "	" "	" "
X-RAYS.....	Necessary only.....	Necessary only.....	Necessary only
SPECIALISTS.....	Yes.....	Yes.....	Yes,—plan pays O.M.A. Tariff, Patient pays difference.
OUTSIDE SERVICES.....	Very limited.....	Only very special cases..	Yes
FEES DUE WHILE SICK.....	Must be paid.....	Must be paid.....	Protected at Mine.
REJOINING AFTER DROPPING OUT.	No, unless new employer	Yes, after waiting period	Yes.
ACCIDENTS, RESPONSIBILITY OF THIRD PARTY.	Association collects.....	Association collects.....	Wait for employee.
SURPLUS FUNDS, IF ANY.....	Transferred to Reserve.	Transferred to Reserve.	None available.
CANCELLATION OF DEPENDANTS	If cancelled, cannot be re-admitted.	Re-apply and be passed by Board.	No restriction.
ENROLMENT OF DEPENDANTS AFTER EMPLOYEE HAS BEEN ADMITTED.	Yes, by Medical Exam. only.	Medical Exam. only....	By Medical Exam. No extra fee.
FEES PAID TO DOCTORS.....	75% of B.C. Tariff.....	100% of O.M.A. Tariff..	Averaged 71% in 3rd year, WITH DRUGS.
LEVY OF ASSESSMENTS IF NECESSARY.	Yes.....	No.....	Not allowed.
DO EMPLOYEERS CONTRIBUTE.	Yes, if they wish.....	Yes, if they wish.....	Yes. \$1.00 per period per employee.
COLLECTIONS.....	Direct by group or through employer.	Direct by group or through employer.	Payroll deductions only, plus 50c. and \$1.00 service charge.
REGISTRATION FEE.....	Yes—\$1.50 each em- ployee.	No.....	No.

The Committee on the Cost of Medical Care gave the following as the annual per capita cost of providing medical care by voluntary groups in the U.S.A.:—

Cost of Adequate Medical Care—Based on Lee-Jones Estimate..	\$ 36 00
Family population of Ft. Benning, Georgia.....	30 00
(Incomplete dentistry; exclusive of eye-glasses)	
Endicott-Johnson employees and their dependants.....	21 02
Roanoke Rapids employees and their dependants.....	17 46
(No dentistry; exclusive of drugs and eye-glasses)	

University of California students.....	14 59
(Selected population—9 months only)	
Employees of Homestake Mining Company and their dependants..	12 48
(No dentistry or home nursing)	
Families subscribing to Ross-Loos medical service.....	10 84
(No dentistry or nursing; exclusive of eye-glasses)	

Mutual Benefit Associations, of which there are a number in Canada, do not all provide identical benefits. For example, the National Mutual Benefit Association provides the doctor's visit, consultant and visiting nurse. Hospitalization is not provided nor is treatment provided for tuberculosis or mental illness. Ten dollars is allowed for a confinement and additional payment for five visits of the doctor. Moreover, there is an indemnity of \$50 up to \$750 for death. The premium is fifty cents a week—\$26 per annum—and this covers the whole family.

In view of the great variations in group and mutual benefit health insurance plans, it does not appear necessary to tabulate numbers of them.

I have a file here on Associated Medical Services which functions, as I have pointed out, in different parts of Canada. There is some information that I marked here which I thought might be of some use to you. The percentage of total payments for doctors' fees in 1938 was 73 per cent; in 1939, 71 per cent; and in 1940, 70 per cent. For hospitalization, 20 per cent in 1938; 23 per cent in 1939 and 25 per cent in 1940. Nursing was 7 per cent in 1938, 6 per cent in 1939 and 5 per cent in 1940. The percentage of earned income expended for medical payments in 1938 was 44·4 per cent; in 1939 it was 60·2 per cent and in 1940 was 66·5 per cent. The doctors' fees in 1939 and 1940 were as follows: the average monthly amount per subscriber in 1939 was \$1.08; that is \$12.96 a year; in 1940, \$1.03 or \$12.36 a year. Hospitalization was 35 cents a month or \$4.20 a year in 1939; 37 cents or \$4.24 in 1940. The average monthly cost per subscriber for nursing fees was 9 cents per month or \$1.08 a year in 1939; 7 cents in 1940 or 84 cents a year. The average monthly cost per subscriber was \$1.52 in 1939; that is, \$18.24 a year. In 1940 it was \$17.64. I have a lot of detailed information here, some of which might be useful to you. I believe I have the administrative costs. It will take me just a moment, to find them. The percentage of income spent on administration in 1939 was 24·6 per cent; in 1940 it was 21·1 per cent. The percentage of income spent on the acquisition of new subscribers was 14·7 per cent in 1939 and 11·1 per cent in 1940. The percentage of income spent on maintaining old subscribers was 9·9 per cent in 1939 and 10 per cent in 1940. The acquisition cost per application in 1940 was \$3.98, so that their administrative costs are fairly high. They amount, I would say, to about 24 per cent. That gives you a fairly good idea of the nature of the voluntary organizations, the services that they provide and the costs.

The CHAIRMAN: Thank you, Dr. Heagerty. Are there any questions about those services?

Mr. KINLEY: Mr. Chairman, the department which is represented by Dr. Heagerty have for years given services to merchant seamen and men in the Canadian Merchant Marine. Has he any figures on the cost and the extent of the services which were provided by the federal government to men upon the sea?

Dr. HEAGERTY: Such costs are available, but I do not believe that they are comparable with health insurance costs; because sailors come to and go from our ports. No sailor is in a port for an entire year, and therefore it is difficult to ascertain exactly how much it costs to provide medical care per capita for sailors. The costs however, are much less than those of Associated Medical and other services. Moreover, the services are complete. We have, however, full and complete and close administration; and of course, as you know, the whole

plan is conducted without a profit. If it were possible to introduce a similar system throughout the whole of Canada for all of the people there is no doubt that the cost of the provision of medical services, hospitals, drugs and so on, would be low.

Mr. KINLEY: I suppose the service is reciprocal with other nations; that is, the seamen's service. If a sailor lands at a foreign port he would get the same medical service as a sailor who lands at a Nova Scotian port.

Dr. HEAGERTY: That is not quite true. The system in various countries varies to a considerable extent. For example, in the United States, all American sailors are treated free of charge. They are given full and complete medical care and hospitalization. A charge, however, would be made for Canadian sailors in American ports.

Mr. KINLEY: Against the ship, but not against the sailor.

Dr. HEAGERTY: In the case of American ships, there is no charge. In the case of foreign ships there would be a charge. But whether it is against the ship or the sailor, I am unable to say. It would be against the ship, I assume.

Mr. KINLEY: Yes. If an American sailor comes to Nova Scotia and is put in the hospital, there would be a charge against the ship. Any sailor who gets sick aboard ship is entitled to go to the hospital and receive care. That would be a charge against that American ship?

Dr. HEAGERTY: Every ship from foreign ports entering Canada pays sick mariners' dues.

Mr. KINLEY: Yes, that is so.

Dr. HEAGERTY: At the rate of 2 cents a year, but not more often than three times a year; and that provides adequate funds to care for the sailors.

Mr. KINLEY: How far does that extend to the fishermen along the coast? We are getting down to very small boats now.

Dr. HEAGERTY: It applies to every vessel that is propelled other than by oars, so that it includes the fisherman.

Mr. KINLEY: What does he pay?

Dr. HEAGERTY: He pays at the same rate. But if the tonnage is quite small, he pays a fixed fee of \$2.

Mr. KINLEY: Therefore the shore fisherman, with a small boat, gets his medical treatment for about \$2 or \$2 and a fraction a year?

Dr. HEAGERTY: That is quite right.

Mr. KINLEY: Per year?

Dr. HEAGERTY: Yes, per year. The object there is, of course, to assist the fisherman. That is really the object of that very low rate.

Mr. KINLEY: The object of it was, I think, to include just the fishermen, that is those who had registered boats. In the case of fishermen in the out-ports it was very meritorious, and there is a very great need for the service. While it costs some money, it seems to me this service is very meritorious.

Mr. WOOD: Dr. Heagerty, there is one question I should like to ask in connection with the fees of the Associated Medical Services. Is it possible that they get their medical services cheaper in consequence of the fact that they engage a doctor to take care of a group of their clients, and ultimately the doctor will probably offer his services cheaper, as he knows he is definitely going to be paid? In consequence of that, has that been, possibly by virtue of that situation, favourable to the Associated Medical Services?

Dr. HEAGERTY: In some cases. As you may have noted as I read, the doctors have accepted the fees that are laid down by their provincial medical associations, and that might give a slightly lower rate than that ordinarily charged by doctors.

Mr. WOOD: It is 75 per cent, I notice, in one case?

Dr. HEAGERTY: Yes.

Mr. HOWDEN: I do not see a very great deal of value in comparing these figures. As a matter of fact, we know what we want in Canada, and we are offering the people general medical coverage—complete and full medical coverage. If we are going to give them that service, we may expect to pay for it. I see here, however, the name of Endicott-Johnson, their employees and their dependants. I mentioned them in an address to the House of Commons several years ago. They give absolutely complete coverage of every kind. They have isolation hospitals, general hospitals, dental specialists, nurses and everything else. They give that entire coverage for \$21.02 a year. Mr. Wood just now asked if the fact that they employ medical men permanently had any effect on it. I think it definitely has. They do not employ the entire medical faculty at large. They have medical men of their own.

Mr. SLAGHT: Where are they?

Mr. HOWDEN: They are in the United States somewhere. They are boot and shoe manufacturers in the United States. The name is Endicott-Johnson. They employ their own doctors. They have specialists of their own, men who have specialized in the various forms of pathology, the various forms of medical disease; and they supply the entire services to the workers and to their families for this \$21.02 a year. That is a very good comparative basis, as it were. But generally speaking, we in Canada have made the proposition to the Canadian people that we are offering them full medical coverage, and we have to pay for that, no matter what the expense of that coverage is compared with other services. I do not see very much use in arguing this at great length.

Mr. JOHNSTON: There is a point that I wanted to get clear. In reading over this brief that Dr. Heagerty issued to us, I notice some places where no dentistry is included and no eye glasses are included. We have been discussing this thing quite freely, and we have often referred to medical services. But I am just wondering now if it is definitely clear that this bill would include dental services and eye glasses?

Mr. HOWDEN: Of course. It is a full service we are offering. That includes everything.

Mr. JOHNSTON: That is what I am wondering. I want to get that clear.

Dr. HEAGERTY: It would include dentistry in so far as it would be possible to provide dentistry.

Mr. JOHNSTON: I just do not understand what you mean when you say "in so far as it would be possible" because it is possible.

Mr. COTÉ: To the extent that there are dentists.

Mr. DONNELLY: When all the dentists are working, you cannot get more than they can do.

Mr. JOHNSTON: We shall have to rectify that in some way or other. There should be included full dental services, the same as full medical services. I doubt right now if there are enough doctors to go around, yet medical services are included in the bill.

Dr. HEAGERTY: Of course, dentistry is included in the bill, but there is a clause which reads as follows: "That the classes of persons entitled to benefit under the program shall not be greater than can be served from time to time in accordance with the standards aforesaid by the dental practitioners with whom arrangements are made."

Mr. JOHNSTON: Who is going to set those standards?

Dr. HEAGERTY: By regulation.

Mr. JOHNSTON: By this committee?

Dr. HEAGERTY: By regulation. You will note that at the beginning of each section, the first statement relates to the provision of regulations. For example, under "Dental Benefit" we find the following. It is section 12 (1) on page 17: "For the purpose of administering dental benefit, the Commission shall, in accordance with regulations made hereunder, make arrangements with registered dental practitioners, including specialists in dentistry, for the purpose of carrying out the program of dental service which may be established in accordance with the said regulations."

Mr. JOHNSTON: What page is that?

Dr. HEAGERTY: That is page 17, section 12 (1).

The CHAIRMAN: What Mr. Johnston is asking is who makes the regulations?

Dr. HEAGERTY: The provincial health insurance commission.

Mr. JOHNSTON: The provincial health insurance commission makes the regulations?

Dr. HEAGERTY: Yes.

Mr. JOHNSTON: What provision is made for eye glasses?

Dr. HEAGERTY: There is no provision made for eye glasses. There is provision for appliances under the pharmaceutical section, but I should say that that does not include eye glasses. I believe that the inclusion of eye glasses would prove costly in this country.

Mr. JOHNSTON: There are a great many medical doctors who specialize in the treatment of the eyes, and they perform all this service up to the grinding of the glasses. Would this bill include that service?

Dr. HEAGERTY: It would include eye examinations and treatment of the eyes, but not the provision of glasses.

Mr. SLAGHT: I wonder if you could clear this point up for me. Perhaps I ought to be able to work it out for myself, but I should like to have your assistance. Take a district where a number of people, settlers, live fifteen, twenty or twenty-five miles from the nearest doctor. Those settlers will come under this provision for the \$12, I take it. Who is going to regulate the placing of the doctor or the seeing to it that a doctor stays at a village or a certain point and continues to render service where it means a long journey? In the case of childbirth, it may perhaps mean a trip that will take him a long time. Does it work out so that they get what is intended to be a complete coverage for the settlers and farmers in scattered areas?

Dr. HEAGERTY: It is the intention to give full and complete coverage to everybody in the country. But it is left to the provincial health commissions to decide how that objective will be attained. You will remember that in certain of the provinces the difficulty mentioned has been overcome by the municipal doctors' system, and by the municipal hospital or what is known also as the union hospital plan. It has also been suggested that health centres be established in various parts of the country; and that, of course, is a reasonable and a practicable suggestion. In regard to the actual movements of doctors, there is no one who has authority to say to a doctor, "You shall or you shall not proceed to a certain place and remain there." The commission, if it is intelligent, will endeavour to make the remuneration sufficiently attractive for doctors to settle in an outpost district. That will be a question of salary or capitation or whatever method the health insurance commission may decide upon.

Mr. SLAGHT: When we pay our contribution over to the provinces, do we have any control in order to see to it that they render real service, or is it entirely at their discretion after they get the money from us?

Dr. HEAGERTY: For that purpose there is a clause in section 11 on page 7, at the top of the page, clause (d) which reads:—

that the Lieutenant Governor in Council shall appoint to the Health Insurance Commission two members to be nominated by the Governor General in Council.

It is proposed therefore, and the suggestion has been made by the advisory committee on finance, that the dominion government shall appoint to each provincial commission two members who shall have responsibility in so far as administration of the dominion financial contribution is concerned, and other matters related thereto.

Mr. ADAMSON: As I understand it, we are here this morning in this committee to make a decision as to whether these rates are adequate or whether we approve or disapprove of them. That is so, is it not? I mean, this meeting is specifically called for that purpose, and we shall have the responsibility this morning of deciding whether we approve or disapprove of these rates. I just wanted to have that cleared up.

The CHAIRMAN: We may not decide. We can at least discuss the matter.

Mr. ADAMSON: But that is what we are here for, is it not?

The CHAIRMAN: That is the principle to be decided.

Mr. ADAMSON: We are discussing this morning simply these rates, and whether we think these rates are too great, whether they are adequate or whether they bear too heavily on certain portions of the community.

The CHAIRMAN: That is right.

Mr. MACINNIS: Mr. Chairman, I was rising to my feet when Mr. Adamson got up. I was going to say that I think we should try to have some order in our procedure, and that we should deal with one point at a time and finish with that point. If we do that, I think we can cover every point in the draft act, or every point that is material for us to consider. But we shall never get anywhere if we continue to proceed in the present manner. I think we should deal with one point at a time, and finish with it.

Mr. DONNELLY: I wish to say a word or two with regard to the fee that is to be collected. I do not think there will be very much objection to the amount of money that the federal government puts into it, whether it is \$100,000,000 or \$200,000,000. In fact, I am afraid that the cry is going to be that we put in the entire amount from the federal government. I do not believe, further, that there will be a great deal of complaint about the \$50,000,000 that we are to collect by way of income tax. Most people will say, "Well, if those people have an income on which they pay income tax, they can pay something into this health insurance fund." I believe the chief bone of contention is going to be the \$12 which we collect from the private individuals. A great many people think that is too much, and that may be so. In my section of the country we have a municipal doctor plan, and the cost of this is collected from the municipality. I think in this case the collecting of this \$12 should be left to the provinces. Conditions will vary in each of the provinces. Some provinces will have manufacturing centres, and there would be no trouble whatever in going to the factory and collecting it from the man's salary. But when you go out into the country, into the farming community, and try to collect from the farmers, you are going to have a great deal of difficulty, in my opinion. I believe you should leave the collection of this \$12 pretty well up to the provincial government and to the provincial authorities. I should like to explain that if it were left to the provincial authorities to make their own arrangements, this \$12, or something in the neighbourhood of this \$12, would be collected by the provincial government in the province in which I have the honour to represent

a constituency, from the people by way of taxation, the same as we collect our municipal fees to-day for our municipal doctors. One of the municipalities in my constituency, for example, has about 1,000 to 1,200 people living there, I suppose. We pay the doctor there \$5,000 a year. He looks after the health of the community. He does the vaccinating, examines the children in the schools, does the medical work, does obstetrical work and things of that kind. He does the major operations. For a major operation he charges one-half the fee only. Of course, in so far as the hospital fees are concerned, the patient pays them himself. We get all those services for somewhere in the neighbourhood of about \$5 each. One thousand people put this up and they get the doctor for \$5,000. Therefore it comes to somewhere around \$5 a head. There may be difficulty in collecting the \$12. They may not think they are getting enough for the other \$7 that they are putting up when they pay \$12. I think this must be more or less governed by your interview or your conference with the provinces, when you can find out what their feelings are as to how this should be collected. I do not think we can lay down any hard and fast rules here and say how the province is to collect it.

Mr. HOWDEN: The \$5,000 applies only to the doctor's remuneration. There are other expenses besides that.

Mr. DONNELLY: I know that. I know that the \$5 only pays the doctor. But on the other hand you must remember that the other \$7 is not collected at all, which will probably pay for the hospital bill besides that. That is only \$100,000,000, and then there is another \$150,000,000. Some people would say that we are putting in too much money for what we are going to get out of it. You are putting up another \$100,000,000 from the dominion government.

Mr. HOWDEN: You cannot do it if you employ the medical fraternity at large. Unless you provide the doctors, you cannot begin to do it.

Mr. DONNELLY: I am putting the problem as it is going to present itself when you put it into practice. I say that it must be left pretty well to the provinces themselves as to how they collect this, as to whether some of it or all of it shall be collected in the way of taxes by the municipality who are hiring and firing the doctors, as the case may be. I think it would be much more satisfactory to leave it to the provinces as to the manner of collection, but leave it to us to say how much they shall pay.

Mr. GERSHAW: I have a specific point which I should like to have clarified while the men who have the figures before them are here. This sheet indicates that a certain proportion of the people of Canada want health insurance and are paying for it out of their private funds. But I surmise that it is only a small proportion of the whole population. The difficulty will be to collect from that great larger proportion of the population who do not now insure themselves and who may find it very, very difficult to meet these payments. For instance, I think there are probably 2,000,000 people now sending in income tax forms in Canada. They will feel that this additional 3 per cent or 5 per cent, plus the \$12, would be a very great burden for those in the smaller income brackets. The question I should like to ask is this. I notice that in this income tax proposal the man who gets, say, \$2,400 a year pays exactly the same as the man who gets \$50,000 or \$100,000 a year. I was wondering if there was any particular reason why the income tax increase stopped at \$2,400 and did not go right up to the high brackets.

The CHAIRMAN: Mr. Bryce, can you answer that?

Mr. BRYCE: I would explain, Mr. Chairman, that the principle that we followed in making this recommendation was that no one should be asked to contribute more towards the health insurance scheme than a limited amount. Whether the limit should be imposed at \$2,100 or \$2,400 or \$2,500, or where that

limit should take effect is, of course, a question of judgment on which one might differ. Whether there should be a limit, though, is really a question as to the extent to which this is an insurance scheme, the extent to which your payments to it, or any individual's payments shall be of the nature of an insurance premium—that is, limited in amount—or whether it shall be in the nature of a tax. We have tried to keep it, to some degree, in the nature of an insurance premium. I think that is the explanation. To have the \$50 limit apply in the way it does, of course, is a matter of judgment.

Hon. Mr. BRUCE: The gentleman who has just spoken answered the problem I had in mind; that is, if this is to be a health insurance scheme, then there must be a contribution from the individual. Otherwise we are coming to what is known as state medicine. I think it is very desirable that there should be a contribution. As to just what that amount shall be may be a question of discussion and decision. I liked the remarks of Dr. Donnelly a moment ago in which he said that there would be no difficulty about the dominion government's contribution but the difficulty would be with the provinces, that the tax of \$12 was going to be objected to, and that it is the responsibility of the provinces which they should look after. It brings up the question I raised on a former occasion, of the necessity of a conference with the provinces on this very question of contribution and some decision being arrived at, because they are called upon to bear a large share of the financial responsibility of this Act. I hope therefore, Mr. Chairman, inasmuch as there is a recess coming soon, that you will not forget to try to arrange a conference at as early a date as possible. I should like to see progress made with the agenda placed before us to-day, so that we might reach some decision here and then get on with the conference with the provinces and get their concurrence or otherwise so that we might make some real progress.

Mr. SLAGHT: If I am in order, I should like to put this viewpoint forward. I take it that we have not advanced beyond the stage where we may discuss the principle of a compulsory tax upon 8,000,000 people or no compulsory tax. My personal view is that it is a very, very grave matter indeed. I questioned Mr. Bryce the other day, and if I understood him correctly, we aim to compel \$12 to be paid to the extent of about \$100,000,000 of the total, and that means that we tax and compel 8,000,000 people to pay \$12. If that be so, I have great doubts that the people of Canada are ready for a compulsory health insurance provision of that kind. I would venture to assert that out of the 8,000,000 people, 5,000,000 people would be opposed to paying it. As we all know, in matters like prohibition, matters that do not carry the judgment of the people, we are doing a dangerous thing if we legislate in advance of public opinion. I do not know whether there has been any sounding board, any Gallup poll or any cross-section of the community tried out in the matter of adding to the taxes of the people; but my judgment is that our taxes in Canada are at the very peak point at which the load can be carried, and that public opinion will revolt if they learn that a bill requiring \$12 per person from 8,000,000 people has been passed by the federal government. I think we should pause indeed before we attempt to force that extra taxation on the backs of our people. That raises the whole question of your method and structure of raising the money. I am in favour of a type of improved health conditions for our people. Everybody is. But I have grave concern as to whether this projected compulsory taxation will meet with general approval and I venture to predict that it will meet with general disapproval. If that be so, we ought not to force it upon our people. I speak only for myself, of course.

Mr. HURTUBISE: I agree with you.

Mr. MACINNIS: Mr. Slaght referred to a compulsory tax. My understanding is that all taxes are compulsory, that no one pays a tax voluntarily. I do not believe that we should be ahead of general public opinion in going forward now

with a comprehensive health insurance plan. We have the fact that wherever groups become organized in industry or in any other way, they find it to their advantage to do in an organized way for the group what it is difficult for them to do as individuals. The purpose behind all these employee groups and other groups, such as Associated Medical Services, that were mentioned today, and the Vancouver group, is that individuals find that by pooling their resources and organizing their services, they can get those services cheaper and better than they can as individuals.

Mr. SLAGHT: But, as I understand it, that is a voluntary matter. Is that not so?

Mr. MACINNIS: Quite.

Mr. SLAGHT: People go into it because they want to go into it. Is that not true?

Mr. MACINNIS: Yes, they go into it because they want to go into it. But if another complete scheme was provided, there is no reason why they would object to that scheme, provided that they felt they were receiving something in return. Let me point out this fact. This is not an additional tax, because there are very few people who, over a period of years, do not pay something for medical services and for dental services—and for dental services particularly. Everyone must pay something from year to year; that is, except the very fortunate few. If it is made clear to these people who are already paying this that what they will pay next year under the health insurance scheme will not be something in addition, but something that they are already paying in another way, I think it would remove any misapprehension. There is something else that we should bear in mind—and this would affect most of us here—and that is that when we require medical service, we pay for that service; but we not only pay for that service, but also pay the doctor for the services he gives to other people who cannot pay.

Mr. HOWDEN: Hear, hear.

Mr. MACINNIS: The logical thing to do then is to spread that over the whole community in such a way that everyone will pay something if he has any ability to pay at all, and everyone will receive services. I consider that it is largely a matter of education, as to whether the public will accept a comprehensive health insurance scheme or not. As a matter of fact, I think the public are demanding it; and it is up to us to organize it in such a way, and to put it over by means of education, that it will be acceptable.

Mr. SLAGHT: Might I suggest to my honourable friend that you cannot educate people by having the tax collector rapping at the door. You have to do it in a different way.

Mr. MACINNIS: You have to do it through service, not through the tax collector.

Mr. COTE: I understand that the collection of the \$12 per capita will be left entirely with the provinces?

The CHAIRMAN: Yes.

Dr. HEAGERTY: That is right.

Mr. COTE: That will be left to them entirely, and they will be free to make such abatement as they wish, but the provinces will be responsible for the \$12 per capita on every adult they have in the province. So at the conference which is going to be held with the provinces, these provinces will be free to modify this per capita amount as long as they bring to the Dominion Government the total amount which this collection represents. So I think that we should con-

centrate this morning on the other part, on the income tax levy. I think that would be more in order, and that we could work more usefully on that other point.

Mr. WRIGHT: I should like to say just a word in reply to Mr. Slaght. Last year we had two groups before this committee who represented the people in this country who were going to receive services through this bill. They were the farmers, through the Canadian Federation of Agriculture, and labour. Both of those groups were prepared to go even further than our bill proposed to go as far as medical health services are concerned. So I think the people of this country are ready for a health insurance program. I think we should get far more criticism if we were to drop it than would be the case if we carried it through. Certainly the people today realize that anything the government gives them must be paid for. It is just a matter of getting distribution of the cost on an equitable basis. I think that is what we should be concerned with, and not with the idea of dropping the proposal.

Mr. HOWDEN: I was going to say, Mr. Chairman, that I find myself agreeing a little bit with everybody and not entirely with anybody, but chiefly with Mr. MacInnis. I feel that the \$12 flat rate is a little bit high. I think that probably, by and large all over Canada, the average family in modest circumstances will fear that \$12 rate. It has occurred to me that if that \$12 rate could be made a \$10 rate, and the level that would be taxed through income tax could be raised a little bit, we should just be doing what we have been doing in Canada for many long years, namely, making the rich man pay the poor man's portion. It is true that the rich man resents that sort of thing, but still he has always done it; and if we have to give medical services of this kind, he will continue to do it because it is pretty well known that medical men get their fees where they can, and it is just the same thing in the end. I believe that the \$12 rate is a little bit high and that if it were possible to figure this thing out on a different basis, say on a \$10 rate, and raise the limit for income tax, our bill would please the people of Canada to a much greater extent.

Mrs. CASSELMAN: Mr. Chairman, I just want to say that I quite agree that there ought to be a comprehensive health service bill. I am very much in favour of it, and I agree with Dr. Howden and others who have spoken in believing that we ought to go ahead with it. There is a question about the level of \$12. If I remember correctly, the \$12 was not considered high by either the representatives of the farmers or by the labour groups. It is only 25 cents a week, the price of a package of cigarettes, a show or something of that kind. It is not very high. I do not know that there would be much objection to it on the ground of being compulsory, as Mr. Slaght says. There would be a great many people who would be jolly glad to get it, and they would consider it as a voluntary service, a voluntary contribution almost, and glad that the dominion and province had made it possible for them to pay as little as that and have this comprehensive service available to them. I should like to see us go ahead with it. I should be sorry to see any suggestion of dropping it. The objection I made last day, and it still reflects my feeling, was that the tax on income is too high. I would prefer to see that contribution come under the general heading of income tax rather than a special levy on income for health insurance; that is, have each person pay the \$12 no matter what the income. Then, of course, those who paid income tax would have the burden to bear for the other services. It might not even come out of income tax. It might come out of the general fund derived from those who are able to buy luxuries which are taxed, from those who are able to buy things that are not for their own good which are also taxed. Excise taxes and so on would contribute to it. My idea would be a flat rate, and I do not know that the \$12 is too high. But I do not like to see this tax on income in that way.

The CHAIRMAN: Mr. Bryce, have you any comments to make on the flat rate, and Mrs. Casselman's suggestion?

Mr. BRYCE: As regards the amount of the flat rate tax on incomes, we set those amounts having in mind the desirability of getting a significant proportion of the costs from that source. We have only managed to get one-third of the costs that are not covered by the direct fee. So we did not feel that was very high. At the same time we wanted to get a rate which appeared to be tolerable when added to the general income tax; that is to say, if you go too high, you get a rate which seemed to us likely to be unpalatable when added to what one might anticipate would be a reasonable rate of income tax for general purposes. On the other hand, if one goes down significantly below the 3 and 5 per cent, you are going to substantially reduce the amount of revenue that you obtain. Mrs. Casselman's suggestion was, I believe, 2 and 4 per cent. It would be difficult to say precisely what reduction that would mean. Presumably it would be something of the order of about \$7,000,000, Mr. Hogarth says—\$6,500,000 or \$7,000,000. That would mean a reduction of \$6,500,000 to \$7,000,000 in the \$50,000,000 yield from this contribution. That, of course, would reduce it from \$50,000,000 to about \$43,000,000.

Mr. HOWDEN: I should like to ask the witness, while he is still on his feet, one question if I may.

The CHAIRMAN: Very well.

Mr. HOWDEN: What difference would it make if the flat rate were lowered to \$10 on the four-member family and the income tax rate were carried higher than it is by a few hundred dollars, if you understand what I mean. Would it not give you about the same result for a family in mediocre circumstances?

Mr. BRYCE: That is, if the flat rate were reduced to \$10?

Mr. HOWDEN: Yes.

Mr. BRYCE: And if the maximum, instead of being \$50 were made \$70 or something of that sort?

Mr. HOWDEN: Yes, exactly.

Mr. BRYCE: Well, you have there a difference in the character of the scheme; a difference in quantity, of course, not in kind. That is, you are making it less a contributory scheme, a less equally contributory scheme, and you are throwing more of the burden on the higher income brackets. Of course, how far one should go in that regard is a matter of judgment.

Mr. HOWDEN: But there would be a point at which the result would be the same?

Mr. BRYCE: Yes, except that you would have to increase the maximum substantially in order to counterbalance the loss on the \$12 fee. To reduce the \$12 payment to \$10 would mean a reduction of one-sixth in \$96,000,000; that is, \$16,000,000. If I may refer to the estimated collections, the figures of estimated yields that were given last week, the total amount collected from persons with incomes over \$1,660 for a single person and over \$2,000 for a married person, would be something like \$26,000,000. To add another \$16,000,000 to those who are paying \$26,000,000 would mean a very substantial increase in the maximum payment.

Mr. LECLERC: May I ask the witness, while he is on his feet, if he can tell us what was the average income of the farmers a few years ago, previous to the war?

Mr. BRYCE: I am afraid I could not, sir. One could get some rough idea, I suppose, from the number of farmers and the various estimates that have been given for agricultural income. I believe that the figures given in the Sirois Report would give some indication.

Mr. LECLERC: But you do not remember?

Mr. BRYCE: I am afraid I do not remember it. It would be very risky to try to guess.

Mr. LECLERC: I think you will find that the average income of the farmer was very low.

Mr. WOOD: What year was that?

Mr. LECLERC: Oh, previous to the war, when the income of the farmers was very low. Like Mrs. Casselman, I should not like to see this dropped. Mr. MacInnis said that it is a matter of education, and that in the course of a few years the people will not mind it, that they will get educated. Take the case of a farmer with income of less than \$1,000. Suppose he had a large family. I am sorry that when you talk about a family in this committee, you always like to talk about a family with two children. Well, that is not a family. Let us talk of a family of four, five or six children, with the father and mother. The father would be compelled to pay from \$100 or maybe \$120.

Mrs. CASSELMAN: No. Children under sixteen are all free. The man who has six children gets the services while he does not pay for any child under sixteen years of age.

Mr. LECLERC: But he will have to pay for those over sixteen.

Mrs. CASSELMAN: But they are contributing to the farmer's income when they are that old.

Mr. LECLERC: But they are on the farm. They are just help.

Mrs. CASSELMAN: They are making his income higher, though.

Mr. LECLERC: The income of the farmer is low. Before the war it was very low. Take the case of a family whose income is very small, where they have no sickness during the year. If you were to compel them to pay \$75 or so, they would find it pretty hard. We might as well not try to add to their difficulties.

Mr. VENIOT: Mr. Chairman, I am in agreement with much that was said by Mr. MacInnis a few minutes ago.

The CHAIRMAN: Order, gentlemen.

Mr. VENIOT: That is so particularly when he referred to the fact that the people of Canada are already paying large contributions towards health services. If the committee will recall, the minister in his presentation last year, and also Dr. Heagerty, stated that the cost of illness in Canada is known, that a special study was made by the Bureau of Statistics in 1935, and the figure was \$240,500,000.

The CHAIRMAN: Order, please.

Mr. VENIOT: A public scheme of health insurance would be merely changing the channel through which this amount would be paid by the Canadian people. I noted also what Dr. Donnelly said concerning municipal doctors in the western provinces. A couple of weeks ago I happened to see figures indicating what these municipal services cost the individuals. These medical services, where municipal doctors are engaged, cost approximately one dollar per month for the doctor's services and for hospital services. That means that in sections of the western provinces where municipal doctors are engaged, the people are presently paying one dollar per month or \$12 per year, which is the amount suggested under this plan. May I further point out to the committee that, a few days ago, a municipal health act was introduced in the Ontario legislature and that one dollar per month was the sum suggested that people who wished to come under this municipal health act should pay. So that, all things considered, the dollar a month figure seems to be that which prevails in the different provinces and in the different plans. I merely wish to bring this to the attention of the committee, so that we may have a basis on which to work.

Mr. ADAMSON: The Federation of Agriculture raised no objection to the dollar a month?

The CHAIRMAN: No.

Mr. JOHNSTON: I should like to say a few words in regard to this measure. In the first place, I think it should be non-contributory. I have taken that stand previously, and I think it is the proper one. I think the whole thing should be taken out of the general revenue. We must remember that this is one of the greatest national schemes that this country has ever entered into. We talk about post-war reconstruction; but there is nothing in the post-war reconstruction period that can be compared with this health insurance plan. So let us not get down to the point where we are going to even suggest that we throw over this plan for the lack of a little bit of money. We have a national bank in Canada which can come to our assistance if we really need money to such an extent that it comes to the point of threatening the implementation of this system. I am not going to stress that point too greatly at this time, but I will say that I agree 100 per cent with Dr. Heagerty, that if we cannot get it out of national revenue, then we should at least cut down on the amount of the contribution as proposed in this bill. I think that \$12 is the maximum amount that should be collected from the individual. As was stated by Dr. Heagerty, there is a growing feeling in this country against the excess charges that are going to be placed against the individual citizens to carry on this program, and \$12 seems to me to be the maximum. I should be more inclined to agree with Dr. Howden that \$10 would be the maximum amount. Mrs. Casselman made reference to the earning power of children on a farm. She comes from the west and she knows as well as I do, I think, that the average farm there is two-quarter sections, and in a great many cases it is one-quarter section. In a very large number of these cases you have quite large families living on a quarter section of land. If you have four or five children over the age of 16 and under the age of 21, I do not care how much they work and contribute towards the earning power of the farm, there is only a very limited amount of revenue that will come from that farm, and it is very small indeed. So I suggest that is not a factor to be considered seriously. These people have only a very small income, and if you are going to tax them to the point where it is going to mean \$100 or \$120, then you are going beyond their means and they cannot possibly do it. I do not think that we should even suggest that this scheme be thrown over for the lack of money. You might just as well suggest that the old age pension scheme be thrown over for the lack of money. I am surprised at Mr. Slaughter when he suggests—and maybe I am wrong in this, but it is the way I understood him—that we should throw this out. I do not know that he suggested that we should throw it out, but he said he thought it was a little premature, maybe.

Mr. SLAUGHT: No; neither the one nor the other.

Mr. JOHNSTON: I recall his speaking in the house in regard to old age pensions and saying that we should, if necessary, use national money for that purpose. Surely we could use some national money for this purpose just as effectively. I would not want to see any thought of this scheme being thrown over for that reason. I am firmly convinced that \$10 would be sufficient to charge per individual.

Mr. SLAUGHT: Mr. Chairman, if I may, I should like to make an explanation. There is apparently a misapprehension as to my attitude. I thought I made it clear that I was in favour of an advanced health bill; I took exception solely to one of the three levies, that is, a tax on 8,000,000 people of \$12 per head—as something that I do not think the country is ready for. I agree that, so far as possible, those who have the most should, under the new order of things, make the greatest contribution; and if my friends are sincere and want to see

that policy carried out, let me remind them of two things. Mr. Bryce will correct me if I am wrong if he has the figures here. We collected under the last budget, or it was estimated that we should collect in the fiscal year which is ending on 31st March, in personal income taxes alone, \$990,000,000, and in excess profits from corporations, \$550,000,000. That is a total of \$1,540,000,000. If you want to give the people a real health service, let us pay for it out of the public purse.

Mr. JOHNSTON: Hear, hear.

Mr. SLAGHT: Because I may tell you that, in the bracket of income taxpayers consisting of unmarried men from \$660 to \$1,200—in that bracket because nobody pays until \$660—there is only \$32,000,000 collected and there are 300,000 people they collect from. With regard to married men in the bracket from \$1,200 to \$1,800, there is only \$55,000,000 collected and there are 600,000 from whom it is collected. So that out of the \$990,000,000 collected from something slightly over 2,000,000 people—and I am thinking now of personal income tax only—900,000 people pay only \$87,000,000. If we are sincere in wanting to keep the burden off the man least able to pay, let us shoulder this insurance plan and pay for it, notwithstanding that my honourable friend Dr. Bruce does not like state medical health services. I think if you review those figures—and Mr. Bryce will correct me if I am wrong in any particular—you will find they are correctly stated to you, and that if you want to put the burden on those best able to pay—and that is what everybody is preaching now under the new order and the new day that is to come—then that is the way to do it and not have the tax collector go around and rap on the door of the little fellow, for \$10 per annum for himself and his wife and any member of his family over 16 years of age. Do not misunderstand me. I am not opposing a health insurance bill. I am taking exception to this compulsory taxation.

Mr. JOHNSTON: Hear, hear. I agree with you 100 per cent.

Mr. WOOD: Mr. Chairman, I find that I am compelled to give my viewpoint—

The CHAIRMAN: There is no compulsion, Mr. Wood.

Mr. WOOD: I thought this was a compulsory health insurance scheme. Possibly I did use the wrong phraseology, but I meant that such compulsion was occasioned by virtue of what some of the other honourable members have contributed to the discussion. I am very grateful to Mr. Slaght for that analysis of the income tax and who pays it. It seems to me that this discussion has resolved itself into trying to pick the goose with the least squawking, as far as I can make it out. But let us not fool ourselves. Mr. Slaght gave a great argument there for the man in the low income brackets. You have not convinced me, Mr. Chairman, that income tax is paid by the wealthy people. It is handed down until it can go no farther, until it finally lands on the man in the basic industry in this country, on the farmer, and he pays it. He pays it often in the form of low prices in comparison with the cost of doing business, and then he pays in the price he pays for goods which he buys, which prices are set by various measures; and often when you put a control upon prices, those controls are destroyed by counter-controls, until finally it rolls on down the whole order until it cannot get any farther and it hits the land. Mr. Slaght's argument is not sound, in my view when he says that the wealthy man pays. True, we all want services if we can get the other fellow to pay for them. But do not let us fool ourselves. Mr. Johnston says that he believes the money for this should come from the consolidated revenue of the country. I can tell you this—and you are not fooling me, whether you are fooling the rest or not, Mr. Chairman—that when you get it from the consolidated revenue of the country, my profession

is the one that is going to pay the major portion of it. I believe that the time has come when we should face these facts, and I believe that the time has come when we should have not only health insurance but should have a satisfactory contributory pension scheme, and that the whole thing should be in one scheme. Let us go to the country on this thing, face it fairly and squarely, and show the people where they can get benefits from it.

Mr. MACINNIS: Where are you going to get the money from?

Mr. WOOD: Where are we going to get the money from? You can earn it, produce, and contribute some of it. The difficulty under the present scheme, and under the scheme you suggest is that the man who dissipates generally wants to get that service for nothing, in so far as health is concerned.

Mr. JOHNSTON: That is not my proposition at all.

The CHAIRMAN: Order, please. Let Mr. Wood finish.

Mr. WOOD: I should appreciate it if I may be allowed to finish.

Mr. JOHNSTON: Do not put words into my mouth.

Mr. WOOD: I am sorry if I have done so.

The CHAIRMAN: Proceed, Mr. Wood.

Mr. McIVOR: Farmers do not need doctors; they are always healthy.

Mr. WOOD: There are three classes into which you can put the average society in regard to health. There are those who pay their way for all the desirable services that they want in the matter of medical service and hospitalization. There is another class who will pay for the minimum service; that is, they will go to the hospital and they will take a public ward and pay for the service; and even then, so far as Ontario is concerned, they do not quite pay for the whole service. Then there are the indigents. Those in the first class that I mentioned, who pay for their own desirable services, help pay for these. My viewpoint is that if we were to get some of this money from those particular sources which have a tendency to impair the health of the nation, it would meet the situation. Very often the man who has been able to pay for his own doctor bill has been the man who has denied himself of some of the pleasures of life, and has made sacrifices in order to put himself in that position. I think that is characteristic. There is the odd man who is lucky, who probably goes to the stock market and makes his fortune, but there are very few of them. I think the great bulk of the people who enjoy a high standard of living to-day consist of those who at some time have made sacrifices in their lives. Then why should they be asked to contribute on behalf of those who possibly have dissipated themselves? We are spending \$350,000,000 on liquor. We are spending \$150,000,000 on tobacco. We are spending about \$80,000,000—that was in 1940—on picture shows. We spend millions of dollars in gambling and horse racing. I believe the province of Ontario has put an additional tax on that, and there is no reason why possibly another 5 per cent could not be put on by the dominion, without any harm. There are pool rooms and many of these things which are indulged in by the more or less weak-minded, if that is the proper word to use.

Mr. WARREN: You had better not use it.

Mr. WOOD: No. I will withdraw that remark, and will put it another way. I will say those who do not feel it is necessary to set aside something for their own social security. These are mediums to which a large number of the people fall victim, and I believe that we could well earmark a good deal of the taxation from those particular sources, because in many respects they have the tendency to impair the health of the people, which is very costly. I believe that if the people are going to have a service, the only way is to make them pay for it; because if you do not assess them or put some responsibility on them, they are going to demand services far in excess of those which we shall be able to afford.

I think that \$12 is a very modest contribution, and I do not think that \$2 will serve the purpose, Mr. Johnston or Dr. Howden, of, as I said, taking the squawk out of the goose when you go to pick it. I do not believe it at all. I do not believe that \$2 will save money. I am definitely opposed to a social security plan that is not contributory. I think that the people should assume a certain portion of the responsibility, that there is a certain class of society that we have to save in spite of themselves. I think it is our duty to do that, and I think that they will have more self-respect if they feel they are contributing to the benefits which they are getting. May I say this in conclusion. Do not let anybody fool you—they are not going to fool me—by saying that by paying this out of the consolidated revenue of the country, the people in the low income brackets and especially the farmers are not paying it. Unfortunately, we farmers have been saddled with a greater burden than those in the cities and towns, which has been brought about more or less by the factor of rolling the burden down to the land—it cannot go any further—and we are assuming that burden. I thank you, Mr. Chairman, for allowing me to take so much of the time of the committee, but I wanted to get this off my chest.

The CHAIRMAN: Thank you very much.

Mr. MAYBANK: Mr. Chairman, I am in the rather odd position of agreeing with the confusion of Mr. Wood but not with his reasons for judgment. I think probably Mr. Wood has been engaged so long in farm work, in killing parasites of one kind and another, that he has come to the condition of thinking that all except farmers are parasites. It is a mistake, I think, for him to continue to believe that the farmer is bound, in the long run, to pay everything in taxation. No person will for a moment dispute the great services the farmer renders in growing an apple or some wheat, and so on. But he is wrong in believing that there is no wealth created by any of those outside the farm fence. Some of these people who haul his stuff away and carry it to the people who want to buy it, do indeed create wealth, and they who create wealth will be the ultimate payers of taxation under the plan suggested by Mr. Slaght or under any other plan. It is rather unfortunate that such a robust and honest character as Mr. Wood should be so continually floundering in this sea of error in which we so often find him. I have never risen before to the defence of a person outside the farm fence. It was just because he was so trenchant in his implied criticism of those outside his fence that I finally felt it were wise to endeavour to set him right, although he is my good friend whom I know to be so extremely obdurate. I am not sure that I have set him right, but I know that he will continue to endeavour to search for the truth. Mr. Slaght has suggested that we should take this levy off these people whom he numbered, these people who do not pay very much income tax now, that very large number of people in quite low income brackets. It seems to me that he has forgotten, however, that in pretty nearly all of these cases there must be \$12 or more paid for medical services now; and to obtain the benefits of this Act for the flat rate of \$12, even to these people to whom he pointed, there would be a reduction right there in the annual payments out made by the vast majority of these people. Some people say that the extremely poor do not pay medical bills. But over a lifetime, I think it will be found that even those in the quite low income brackets do pay at least more than \$12 per annum. I am sure of that from my observations of those going to our hospitals in the cities. For example, I am thinking of these proper families, or these proper-size families which Mr. Leclerc has referred to. I do not know whether he said it or not, but I think he feels that a family of two or three is not a family at all but just a primer. But at any rate, take the case of these large families. In a great number of these cases there must be even maternity bills paid out which would be in excess of the amount called for in this \$12 levy.

Mr. HOWDEN: Not necessarily.

Mr. MAYBANK: No, not necessarily. In the first place, it is not necessary to be paid because I think Dr. Howden may have in mind that the bill is incurred and not paid; and in the second place, I suppose there is the usual number of cases where the medical man is not even called on; some friendly woman performs the services of a midwife. Still in the great number of cases I think there must be an even greater maternity bill paid out for those large families. There is something else which makes it very necessary to fix this on a basis where everybody will make some contribution, and it is this. Just as sure as you have any kind of scheme in which people make any payments, then you will get the beneficiaries of the scheme on the one hand constantly demanding more, and you will get another section of the public looking on it as charity. You will have the beneficiaries of the scheme branded by some as the recipients of charity; and at times when the exchequer is low, one of the first places that governments will endeavour to make a cut is in those particular services. You will not get a well-informed public watching it. You will get into this position, which was very well illustrated in the old country when they were paying out what was called the dole. They began, you will remember, by paying out unemployment insurance, and the fund went bankrupt. They then doled out of the treasury into that fund, and it was not long before these men who for a long time had been paying unemployment insurance, were objecting that every person was talking about them being on the dole. That is just what we shall have here if we do not have the people contributing. They will not be as watchful as they should be. Everyone will be striving to take it away from them. In fact, it will just come about that before very long it will be considered as a sort of paternalistic charity and it will not be good for any of us. It will not be good for the recipients. It will not be good for anybody else. I would say on the question of whether there should be a contribution or whether there should not be a contribution, that I would vote in favour of the former, in consideration of the importance of human dignity in this country that is just now in the making.

Mr. WATSON: Mr. Chairman, at the last session I tried to clarify certain points, but I am afraid that I did not make a very good job of it. I have prepared a statement that I shall follow fairly closely in the hope that I may make clear the points that I was trying to make clear last day. I hope that by confining attention to primary issues, perhaps we may get better direction in our procedure in the discussion of the subject afterwards.

The primary objective in establishing health insurance would seem to be to enable people to pay for the irregular, fortuitous and, too often, crushing costs of the health services by making a substantially uniform annual contribution to a health insurance fund. Like most insurance contributions or premiums, there may have to be some variation in the amount to be contributed from year to year or over the years.

Health services are personal needs of life, and they are quite as personal as our needs for food, clothing, shelter, light, heat, etc. If our needs for health services were, like these other needs, substantially uniform from year to year, we should of course never have heard of health insurance. We should have been accustomed to pay for them in the ordinary course, as for other personal needs of life, out of wages, salaries and other income. Taxation properly falls on income left over after personal needs are paid for.

When health insurance is in operation it will be the same, so far as our personal financial arrangements are concerned, as if our needs for health services were in fact uniform from year to year. This plainly indicates that we should pay our health insurance contributions out of our wages, salaries or

other income if we are able to do so. In the cases where that would, on social grounds, be too burdensome, it is proper that the contributions should be waived in whole or in part as the circumstances may demand. Many life insurance policies provide for waiver of the premium in the event of the insured being unable to earn owing to ill health. Such a policy is the more truly insurance in that it not only insures a sum of money at death, but also insures the waiver of premium in the event of inability to earn on account of ill health. It is so under health insurance, but under health insurance the waiver contributions will include inability to earn from any cause, and will provide for partial waiver if earnings happen in any year to be inadequate. This enlarged waiver would be too difficult to administer under life insurance, but it is quite practicable under state health insurance. It is proper that contributions waived under health insurance should be financed out of general taxation, the same as assistance to poorer people for food, clothing and other personal needs is financed out of general taxes.

It is in accordance with insurance principles that young people on leaving our schools and universities and entering employment should be enabled to pay a contribution high enough to cover all of the unknown hazards of health services, both for themselves and for their dependant children, i.e., an inclusive contribution for themselves and children who may at any time thereafter be dependent on them. Thus the adult per capita contribution may be arrived at by dividing the total health insurance costs by the adult population.

In economics it is clearly not taxation that the individual should be required to pay his health insurance contribution in full, if he is reasonably able to do so, nor does the contribution become a tax if in some cases and in some circumstances the contribution is waived in whole or in part on social grounds; and the scheme does not cease to be insurance as a consequence of waiver but rather it becomes all the more insurance in that the contributor is insured his health services, for himself and dependent children, and is also insured against his possible inability to earn sufficiently to pay his contributions in full. The fact that the contribution may not in each case all be collected through one collecting agency does not make the contribution a tax if it would not be a tax if all were collected through one agency. Whether there should be one collecting agency, or two or more, must be settled on grounds of expediency.

In the ordinary course people are prepared to pay for their food, clothing, shelter, light, heat, etc., and in addition to provide assistance out of general taxation for those unable to do so. There does not seem to be any reason why those who are in any year able to pay the full health insurance contribution should not be ready and glad to do so and, in addition, to pay taxes to provide for waived contributions of those unable to pay; some of those paying in full in any year may also at some time themselves be unable to pay in full.

The fact of contribution at once identifies the persons who are qualified for benefit and eliminates all difficult questions of residence, etc., and establishes a basis for transfer of rights in the event of temporary change of residence.

On the question of the amount of \$12, I should like to point out that the personal needs of life of the people in Canada probably run to something of the order of \$5,000,000,000. Those personal needs of life are intended to be supplied out of our earnings or income, before we pay taxes at all. That shows how puny, after all, the taxation resources of the nation are, when it comes to supplying the personal needs of life.

Mr. COTÉ: I think it would speed up the deliberations if we were to agree on one of the alternative plans of collecting contributions which have been so well prepared by Dr. Heagerty. As for myself, I would favour the second alternative, which is retaining the amount of the contribution at \$12, abolishing collection by means of the income tax, and supplementary payment through the national revenue in lieu thereof. I do not think it would make much difference, getting \$12 as the basic rate instead of \$10 which has been submitted—after all, it is only a matter of four cents a week—so I would strongly favour this second alternative, and if it is in order I would move it at this time.

The CHAIRMAN: The minister wishes to answer a question at this stage of the proceedings.

Mr. SLAGHT: May I ask a point of information? Have any of our technical friends given us an estimate of what it will cost to collect \$12 apiece from 8,000,000 people?

The CHAIRMAN: No. You have not that prepared, have you?

Mr. MARSHALL: No.

The CHAIRMAN: We can get that information for you, Mr. Slaght.

Mr. SLAGHT: I think it would be tremendous.

Hon. Mr. MACKENZIE: Dr. Gershaw at the meeting before the last asked a question, and I have the reply from the committee on finance. It is as follows:

In answer to the question by Mr. Gershaw at the meeting of the Special Committee of the House of Commons on March 9, 1944, namely:

What would be the additional cost if the Dominion looked after those now between the ages of 16 and 21 years who are in school and university and not earning money in any way?

the Committee on Health Insurance Finance begs leave to report that the attached table has been prepared from a special run of the Census cards of the population between the ages of 16 to 20 years, inclusive, and shows those attending school by single years of age and sex, for the provinces, 1941.

The Committee cannot say which of these students have outside income because such figures are not available. It is impossible to ascertain, for instance, how many of these students earn money during their holidays. The Committee would point out that exempting this particular group would mean favouring families who can afford to keep their children at home or allow them to continue school and university as against the families in such economic status who are forced to send their children out to work. The Committee did not feel that families who are forced to send their children to work at an early age should be discriminated against, and would further point out that most of these people are now paying in one form or another for medical services. Therefore, on the factual data available, the Committee on Health Insurance Finance can merely state that if the Dominion assumed responsibility for the \$12 contribution of all students between the ages of 16 and 21 years, the additional cost would be in the neighbourhood of three and one half million dollars.

POPULATION 16-20 YEARS OF AGE, INCLUSIVE, ATTENDING SCHOOL, BY
SINGLE YEARS OF AGE AND SEX, FOR PROVINCES, 1941
(Provincial figures)

Province	Total	Percentage of total population 16-20 years	Age				
			16	17	18	19	20
CANADA.....	265,311	24.0	108,455	70,169	45,102	26,610	14,975
M.	126,336	22.6	51,682	31,999	20,989	13,324	8,342
F.	138,975	25.4	56,773	38,170	24,113	13,286	6,633
Prince Edward Island.....	1,845	20.3	817	478	300	167	83
M.	776	16.7	334	183	133	77	49
F.	1,069	24.1	483	295	167	90	34
Nova Scotia.....	13,377	23.9	5,667	3,549	2,156	1,296	709
M.	5,608	19.8	2,440	1,459	830	539	340
F.	7,769	28.2	3,227	2,090	1,326	757	369
New Brunswick.....	10,552	22.0	4,366	2,806	1,786	1,055	539
M.	4,608	18.8	1,950	1,123	720	519	296
F.	5,944	25.4	2,416	1,683	1,066	536	243
Quebec.....	56,111	16.3	24,507	14,792	8,762	4,924	3,126
M.	30,088	17.5	12,523	7,580	4,826	3,047	2,112
F.	26,023	15.1	11,984	7,212	3,936	1,877	1,014
Ontario.....	84,641	25.1	35,524	21,607	14,269	8,347	4,894
M.	39,839	23.3	16,753	9,467	6,597	4,251	2,771
F.	44,802	27.0	18,771	12,140	7,672	4,096	2,123
Manitoba.....	20,193	27.8	8,183	5,702	3,420	1,869	1,019
M.	9,448	25.9	3,901	2,602	1,503	906	536
F.	10,745	29.6	4,282	3,100	1,917	963	483
Saskatchewan.....	28,888	30.4	10,980	7,845	5,143	3,258	1,662
M.	13,004	26.8	5,106	3,537	2,189	1,393	779
F.	15,884	34.1	5,874	4,308	2,954	1,865	883
Alberta.....	26,406	34.1	9,526	6,899	5,091	3,235	1,655
M.	11,773	30.2	4,463	2,998	2,192	1,362	758
F.	14,633	38.1	5,063	3,901	2,899	1,873	897
British Columbia.....	23,250	34.6	8,865	6,479	4,162	2,457	1,287
M.	11,173	33.0	4,205	3,045	1,995	1,228	700
F.	12,077	36.2	4,660	3,434	2,167	1,229	587
Yukon.....	36	.....	12	11	10	2	1
M.	13	.....	3	5	2	2	1
F.	23	.....	9	6	8	.....	.....
Northwest Territories.....	12	.....	8	1	3	.....	.....
M.	6	.....	4	.....	2	.....	.....
F.	6	.....	4	1	1	.....	.....

Mr. HOWDEN: Just for the sake of discussion, and in order to bring this matter to a head, may I say this. You already have a motion before the chair that we agree upon a flat rate of \$12 and the provisions of the bill as they are at the present time before us; as a matter for discussion and to finally get the matter to a vote and disposed of, I will move that the flat rate be \$10 a head.

The CHAIRMAN: Pardon me, but Mr. Coté's motion was not seconded.

Mr. HOWDEN: It does not need to have a seconder.

Mr. COTÉ: I made a motion which was supporting the second alternative, but retaining the \$12.

The CHAIRMAN: That is (b) on page 2?

Mr. COTÉ: Yes.

Hon. Mr. BRUCE: I shall be glad to second the motion of Mr. Coté.

The CHAIRMAN: It does not need a seconder.

Hon. Mr. MACKENZIE: That is all right. It is a nice thing to do.

Mr. HOWDEN: What is the alternative?

The CHAIRMAN: \$12.

Hon. Mr. MACKENZIE: May I ask a question in regard to the motion which was seconded by Mr. Bruce?

The CHAIRMAN: Yes.

Hon. Mr. MACKENZIE: I understand Mr. Coté was supporting (b) on page 2 of the agenda.

Mr. BRYCE: I am sorry, but I have not seen it.

Mr. WOOD: Speaking to the motion again, I should like to draw the attention of the committee—

The CHAIRMAN: Wait till this question is answered, please.

Mr. WOOD: I am sorry.

Hon. Mr. MACKENZIE: As I understand the motion, it is that a \$12 flat rate be levied, plus all the rest transferred to the national revenue.

Mr. COTÉ: Yes.

Hon. Mr. MACKENZIE: The question I should like to ask is this. What would be the difference in general terms between income tax assessment as between the \$100,000,000 you show in the finance committee recommendation and the \$150,000,000 which would result from Mr. Coté's motion? Is that clear?

Mr. BRYCE: What difference that would make to the post-war income tax rates?

Hon. Mr. MACKENZIE: Well, at the rates of to-day or post-war. Of course there will be reductions made in certain directions and increases in others. Is it possible to assess that?

Mr. BRYCE: We could not predict in advance where your additional \$50,000,000 would rest. If it was to come from income tax, on the present income tax revenue—the estimate in the current year was some \$930,000,000; that is including the refundable portion of the tax—at addition of \$50,000,000 added to the \$100,000,000 that is already contemplated would certainly mean an increase of considerably more than 10 per cent in present income tax. But of course, we cannot expect post-war income tax revenue to be at these present wartime rates. Therefore it would mean, if it were to be all collected from income tax, a substantially greater increase than 10 or 15 per cent.

Hon. Mr. MACKENZIE: Was it the intention under the present recommendation to collect that \$100,000,000 from income tax alone or from what sources?

Mr. BRYCE: In our recommendation we did not specify that it was to be collected from any particular sources of revenue.

Hon. Mr. MACKENZIE: What I am trying to get at is this. How much more burden would be placed on any particular phases of government activity as between \$150,000,000 and the \$100,000,000?

Mr. BRYCE: There would be another \$50,000,000 to be found as part of the general funds of the dominion. I would suggest that the important point is this: will it be easier for the dominion to cover all its obligations if a portion of what we collect along with income tax is earmarked as a contribution for health insurance or will it not? It is a difficult question of judgment to say whether the public will be more prepared to pay the same amount, knowing that some of the income tax is going into health insurance, let us say, or whether they would be more prepared to pay it if a specific portion was earmarked for health insurance.

Mr. McCANN: It does not sugar-coat it at all.

Mr. BRYCE: No, it does not. It is a question, I think, that has to be viewed really in the light of the dominion's financial position as a whole. You cannot divorce things of this magnitude from other budget problems of the dominion; and if this is not collected as a health insurance contribution, it must be found somehow in the dominion budget. If the committee on social security does not find it, the committee on ways and means must.

Mr. JOHNSTON: Do I understand from what Mr. Bryce says that he means by earmarking that it would be indicated there on your income tax form? It may be indicated in the general estimates of the dominion when they were making up the budget for the year, but certainly I would not think he would mean that there would be a further place set out on the income tax form, showing an increase of 5, 6 or 7 per cent to be used entirely for health services; because you are just inviting a crack on the nose when you do that. I think we should just leave it as general revenue.

Mrs. CASSELMAN: Also, would not general revenue include not only income tax but, as Mr. Wood has said, taxes in other directions?

Mr. COTÉ: From other sources.

Mrs. CASSELMAN: Yes, from other sources; that is, from excise, or as he has said, tobacco or whatever it is, import duties and so on. It all goes into the regular channels. There is another suggestion which has been made to me privately. I do not know whether it is worthwhile giving it to the committee or not. It is that perhaps some of this might be raised through a sweepstake.

Hon. Mr. MACKENZIE: I do not know where that came from.

The CHAIRMAN: Order, please. Mr. Côté's motion will be discussed at the next meeting.

Mr. SLAGHT: Will Mr. Bryce tell us what the view of the finance committee was in endeavouring to raise this sum out of the \$2,750,000,000 general revenue, because that is what we budgeted for this year? Why do we select the \$990,000,000 budgeted for personal income tax, where income tax is paid on incomes down as low as \$660, instead of taking it out of the general revenue? There must be a reason in the minds of these financial gentlemen for that.

The CHAIRMAN: Mr. Bryce, can you answer Mr. Slaght's question?

Mr. BRYCE: Very briefly, the reason we selected the income tax was to make this particular contribution levied in accordance with the ability to pay. We could not achieve that by attaching it to any other particular tax unless we can assume that expenditure on tobacco or liquor somehow measures the ability to pay more precisely than does income tax. As far as getting it out of the two and three-quarter billion dollars of revenue is concerned, I think it would be optimistic to expect that much revenue from general taxation after the war. It is not a question of whether we can afford it with revenue of that size, but rather a question of what we may expect after the war.

The CHAIRMAN: Thank you, Mr. Bryce.

Mr. WRIGHT: Mr. Bryce has said that they used income tax because it represented the ability to pay. I cannot follow him in his argument, because he stopped at \$2,200 and \$1,660 as far as the individual is concerned. All the proposals before the committee appear in the agenda. I find myself very much in accordance with the motion of the member who spoke a few moments ago, to the effect that we accept (b) as the proposal here, and take anything over the \$12 out of the consolidated revenue fund. As a matter of fact, I would go farther than that. I believe that we should take even a greater portion out of the consolidated revenue fund. I believe we should have some personal contribution whereby the people recognize that they have a responsibility for this.

But I would suggest that the \$12 is too high, taking into consideration the economic conditions in certain provinces and certain districts in Canada. I know that that \$12 contribution is going to be a serious matter for families in certain areas, especially in western Canada during a year in which there are crop failures.

Mr. LECLERC: Western and eastern Canada.

Mr. WRIGHT: And eastern Canada too. I think that applies equally to eastern Canada. I have been through many parts of Quebec where I know the \$12 contribution would mean a very serious amount out of the incomes of families. I would suggest as an alternative plan for the consideration of the committee that we take 50 per cent of the total cost of our scheme from the consolidated revenue of the Dominion, that we take 25 per cent from the consolidated revenue of the provinces, and that 25 per cent be borne as a registration fee by the individual. That would represent, I imagine, approximately a \$6 registration fee for the individual and his children over 16 years of age, with the contribution then of 25 per cent from the consolidated revenue fund of the provinces, because the provinces will be responsible for the administration, and 50 per cent from the consolidated revenue fund of the Dominion. I think the fairest way of collecting the cost of this scheme is out of the consolidated revenue fund rather than against the personal income, because the consolidated revenue fund represents the ability of this Dominion to pay for the services which we demand of our governments. If our taxing system is fair, and I think it is reasonably fair, that represents the total ability of the Dominion to provide certain services for the people living in the Dominion. As Mr. Wood has stated, there are certain other things. He mentioned the liquor industry, and that there is \$350,000,000 spent for liquor in Canada. Well, approximately half of that goes into your consolidated revenue fund in the form of taxation. Therefore it seems to me that the proper place to place your charge is against the consolidated revenue fund. I think that with the personal contribution of 25 per cent in the form of a registration fee, 25 per cent taken from the consolidated revenue fund of the provinces and 50 per cent from the dominion, you would have a scheme which would be easy to operate. You will not have to set up another taxation scheme which has to carry on medical health services in this dominion. The speech from the throne indicates that we may have a compulsory old age scheme brought in, which will mean that we may have to set up another form of taxation or another scheme of taxation. We will find ourselves with half a dozen different types of taxation in this country, until the people will get discouraged with the whole thing, and they will want to get rid of all the social security services in the dominion. So, I think that a charge against the consolidated revenue fund is the fairest way in which we can finance this scheme.

Mr. CHAIRMAN: Mr. Coté's motion and any amendments thereto will be discussed at the next meeting.

Mr. MACINNIS: I move that we adjourn.

The committee adjourned at 1.10 p.m. to meet again at the call of the chair.

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Canada - Social Security
- Cttee on, 1944

SESSION 1944
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

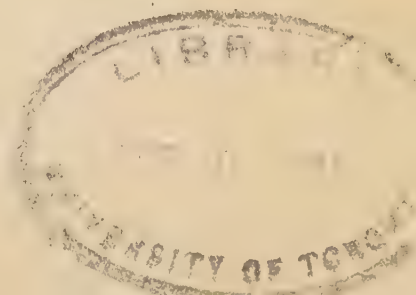
No. 5

THURSDAY, MARCH 30, 1944

WITNESSES:

- Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
- Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;
- Mr. R. B. Bryce, Financial Investigator, Department of Finance;
- Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health.

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1944



MINUTES OF PROCEEDINGS

THURSDAY, March 30, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Bourget, Breithaupt, Bruce, Claxton, Cleaver, Coté, Donnelly, Fulford, Hatfield, Howden, Johnston (*Bow River*), Kinley, Lalonde, Lerclerc, Lockhart, MacInnis, MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Veniot, Warren, Wood and Wright—27.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;

Mr. J. E. Howes, Research Staff, Bank of Canada.

Mr. Wright submitted a brief on behalf of the Dominion Veterinary Council, which, on motion of Mr. Breithaupt, was ordered to be printed in the evidence. (*See Appendix "A".*)

Mr. Howden read a statement outlining the cost of Health Insurance in Great Britain.

Dr. Heagerty, Mr. Stangroom, Mr. Bryce and Mr. Gunn were called and examined.

Mr. Coté, with the consent of the Committee, withdrew the motion he moved on March 22, consideration of which was deferred until this meeting. The said motion reads as follows:—"That the alternate plan of collecting contributions retaining the amount of contribution of \$12.00, abolishing collection by means of income tax, and supplementary payment through the National Revenue in lieu thereof, be adopted".

Hon. Mr. Bruce moved:—"That the Committee approves the principle that the plan of partial contributory Health Insurance be adopted." Motion adopted on division.

Mr. Coté moved:—"That a flat contribution rate of \$12.00 per adult per annum be suggested to the provinces, leaving the provinces to modify this basic rate without changing the total amount for which the provinces would be responsible on a per capita basis."

Discussion followed.

On motion of Mr. Donnelly the Committee adjourned at 1.10 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS, March 30, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, the Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Mr. Wright, I understand that you have a brief to present.

Mr. WRIGHT: Is it the desire of the committee that I read this brief?

The CHAIRMAN: I do not think it is necessary, unless the committee wishes it. Perhaps you might state from whom the brief comes.

Mr. WRIGHT: This is a brief from the Dominion Veterinary Medical Council to be presented to this committee. It points out, among other things, the very close relationship between disease in animals and human diseases. It goes on to show that just as there are occupational risks in industry, there are also occupational risks in agriculture, and that any medical health scheme in Canada should take this into consideration. It states at one point:—

To those familiar with health problems which directly affect the farmer and other persons residing in rural districts and which, no doubt, contribute greatly to the poorer health of these people, it is disappointing that no recommendation has been made to inaugurate the type of public health service which would benefit this particular group. Although there is, perhaps, no aspect of public health which is of more importance to the rural resident than is the control of diseases common to man and lower animals, this phase of public health has not even been mentioned.

It is interesting to note that of the ten conditions listed as requiring further research, six are diseases common to man and domestic or wild animals and, of course, affect those residing in the rural rather than urban areas.

The recommendation of the council is contained in the last paragraph in which they state:—

In summary, it is respectfully submitted that any plan to establish public health units is incomplete which fails to take into account and provide in its organization for dealing with animal diseases transmissible to man.

It is recommended that provision be made for the recognition of veterinary medicine by altering subsection 4 to read as follows: "Unless otherwise prescribed, the provisions of the last prescribed subsection shall apply only to members of the dental profession, the pharmaceutical professions and the profession of veterinary medicine."

The members of the committee would be well advised to read this brief, as I believe it has many very good ideas in it.

The CHAIRMAN: Mr. Wright, can you tell the committee anything about the research institute from which this comes? If you are not familiar with it, it does not matter.

Mr. WRIGHT: No; unless I read the whole brief it would be difficult. It lists six particular diseases which are dangerous at this time and which need attention.

The CHAIRMAN: Thank you, Mr. Wright. Is it the wish of the committee to place the brief on the record?

Some Hon. MEMBERS: Yes.

Mr. COTE: Do I understand that this group did not appear before the committee last year?

The CHAIRMAN: No.

Mr. COTE: This is the first time they have made any representation?

The CHAIRMAN: This is the first time.

Mr. HOWDEN: I am afraid the brief will get very little consideration unless it is perused here in committee and read through.

The CHAIRMAN: My suggestion was that it be placed on the record and we can discuss it after having read it.

Mr. HOWDEN: Well, perhaps.

Mr. WRIGHT: It would not take over fifteen minutes to read it, I do not think.

Mr. COTÉ: It would expedite matters more to place it on the record and take it up later.

Mr. LALONDE: It would be hard to discuss this brief until we had a veterinary with us.

The CHAIRMAN: If we put it on the record, we can devote some time to discussion later.

Mr. BREITHAUPT: I would so move.

The CHAIRMAN: It is moved that the brief be placed on the record for further discussion.

Mr. HOWDEN: I have something here which might be of interest to the committee.

The CHAIRMAN: Just a minute, please. Is that motion carried?

Some Hon. MEMBERS: Yes.

Motion agreed to.

(See Appendix A.)

The CHAIRMAN: All right, Mr. Howden.

Mr. HOWDEN: This is with relation to the new health insurance plan in Great Britain (England, Wales and Scotland).

NEW HEALTH INSURANCE PLAN IN GREAT BRITAIN
(ENGLAND, WALES AND SCOTLAND)

£—\$4.45			Population, 46,466,700	
	Millions	Millions	Per Capita	Per Capita
Annual Cost of Health Insurance...	£147.8	\$657.7	\$14.15	£3.3.7
Total exchequer grants	£ 94.4	\$420.1	\$ 9.04	£2.0.7
Local authorities	53.4	237.6	5.11	1.3.0
Total	£147.8	\$657.7	\$14.15	£3.3.7

Hon. Mr. BRUCE: What per cent is that amount which the local authorities pay? Have you that worked out?

Mr. HOWDEN: It is not worked out in percentages. Then, if you want it, there is a breakdown of exchequer grants.

	Millions	Millions	Per Capita	Per Capita
Direct grant doctors and drugs....	£ 33.4	148.6	\$ 3.20	£14/6
Hospitals general (municipal, voluntary, metal and infectious disease)	43.4	193.1	4.16	18/10
Home nursing and dental (total cost £18)	9.0	40.1	.86	3/10

Hon. Mr. BRUCE: Did you say .86?

Mr. HOWDEN: Yes, for nursing. That is per capita. They are taking very excellent care of all medical service, as it were,—doctors, nurses and dentists; and out of this fund they are actually providing a pension for medical men after a certain number of years. It seems to be pretty good management all through.

Mr. DONNELLY: What services do you get? What do you get for your money?

Mr. HOWDEN: Total services, everything. It is total service, the same as we get here—medical and dental service; everything.

Mr. DONNELLY: Operations?

Mr. HOWDEN: I think operations too.

Dr. HEAGERTY: Everything. The British plan provides everything we have in mind and that we have included in our proposals to you. It is an extremely comprehensive plan, and as pointed out by Dr. Howden, the exchequer is bearing the brunt of the cost. I do not recall the exact figures, but he pointed out I think that the exchequer will pay approximately \$9 and some cents per capita and the individual will pay \$5 and some cents. That \$5 and some cents, I believe, includes children, Dr. Howden?

Mr. HOWDEN: Yes.

Dr. HEAGERTY: So that the cost to the adult would be one third more than that. There are approximately 16,000,000 children in England, so that amount of \$5.11 would be raised to something over \$7. That would be the contribution.

Mr. HOWDEN: \$5.11, yes.

Dr. HEAGERTY: That would be the contributoin of the individual by means of rates to the local authority.

Mr. DONNELLY: How do you account for the fact they are only charging \$14 and something for all the medical services and we are asking \$21 in this country?

Dr. HEAGERTY: There is a difference in the cost of living and perhaps in the method of providing the medical services.

Mr. DONNELLY: There is a lot of difference.

Dr. HEAGERTY: We have preferred to accept figures that are more indicative of the cost of living in Canada, such as American and Canadian figures, rather than European figures and British figures. We expect that the cost of providing medical care in England would be less than in Canada. I might say that their scheme is almost identical with our own. They are leaving it to the medical profession to decide whether the doctor will practice as an individual, as one of a group, or in a health centre, whether he will be paid on a capitation basis, on a fee basis or on a salary basis. They are providing free treatment for mental diseases, for tuberculosis and in fact everything that is known in the way of preventive medicine and treatment, including dentistry, at the estimated cost, the figures for which I think are quite correct.

Mr. HATFIELD: The area served would have something to do with it, comparing Canada and Great Britain? Would that not have something to do with it?

Dr. HEAGERTY: It might be a factor. But our figures are based on the present per capita cost.

Mr. DONNELLY: There is quite a difference. Where they charge \$14, we charge \$21.

Hon. Mr. BRUCE: I just wanted to make clear for Dr. Heagerty, if the committee will be good enough to allow me to do so, that this amount of \$5.11 contributed by what is called the local authorities in England is a contribution by the individual.

Dr. HEAGERTY: That is right.

Hon. Mr. BRUCE: Therefore it is contributory insurance. That is what I want to bring out. Even though it is by taxation, it is the individual who is contributing as well as the state.

The CHAIRMAN: Does that mean that the individual makes a contribution to the municipal treasury and in turn that is passed on? I do not quite understand the method of payment. You say it is the individual and Dr. Howden says it is the municipal authorities.

Hon. Mr. BRUCE: It is the local authorities, but I understood Dr. Heagerty to say that this was a contribution. Therefore it is contributory insurance.

Dr. HEAGERTY: It is contributory. It is on the basis of rates, rates that are paid to county councils and borough councils. It is practically the same principle we have in mind here. We are suggesting a rate of \$12. There the rate will be \$5.11 and the exchequer will pay the difference.

Hon. Mr. BRUCE: That is the point I was trying to make clear.

Mr. CLEAVER: How long has the British Act been in force?

Dr. HEAGERTY: It has not been in force yet. As a matter of fact, it is under discussion. They have followed the same procedure that we have in Canada. They have first consulted with the profession—the doctors, the dentists, nurses and others. I understand it is now before the House of Commons for discussion.

Mr. MACINNIS: Those figures are from the White Paper.

Dr. HEAGERTY: Those are from the White Paper, I understand.

Mr. VENIOT: One point which we must not lose sight of in establishing a comparison between medical service cost in Canada and in England is the fact that in Canada a large part of the cost of medical services is made up because of the mileage the doctors have to charge for the long distances they have to travel.

The CHAIRMAN: That was Mr. Hatfield's point, I think, in regard to the area covered.

Mr. VENIOT: Yes. We have to charge mileage in a lot of cases; and I venture to say that a doctor practising in a rural district is obliged to charge at least a third for mileage in making out his costs.

Dr. HEAGERTY: In addition to that, if I may be permitted to say so, I understand that it is the intention to establish health centres in so far as it is possible to do so throughout England, and that it is proposed that the doctors in those centres will be paid on a capitation basis. That, of course, would make a very great difference in cost. If you will remember, the last day we were here, I read to you some figures relating to the cost of the Associated Medical Services. The average amount collected by the doctor per insured person for his services in the course of the year was \$12. We have figured the per capita cost on the fee basis at \$9.50, which is lower than that usually charged. But I believe that the cost on a capitation basis and salary basis in some areas in England will be lower than the \$9.50 that we have estimated here. So that the areas and other factors are an important consideration.

The CHAIRMAN: Are there any other questions on the British system? If not, I believe Mr. Stangroom has some answers to questions which were asked.

Mr. STANGROOM: Mr. Chairman, in order to answer various questions which have arisen during recent sittings of the social security committee, and so as to explain further the financial recommendations, I would ask your permission to make a few remarks.

The draft health insurance bill and the supplementary material which was referred to us for study contemplated an annual contribution on behalf of every adult of about \$26. The bill provided for what was considered to be an

expensive administrative machinery to assess the income of individuals applying for abatements of this contribution, which the provinces were required in large part to absorb.

It has been estimated that, based on the figure of \$21.60 *per person*, the average amount *per adult* spent at present by individuals for medical care for themselves and their children is about \$35 a year. This average includes those who can pay nothing or only a few dollars towards their doctors' bills, but does not include indigents.

It should be borne in mind that over 60 per cent of wage earners in the 1941 census reported an income of less than \$950 a year.

This average of \$35 per adult spent at present is more than the \$26 contribution originally suggested for health insurance, yet it was estimated that the provinces would have had to assume a total of nearly \$68 millions in abatements of this contribution.

In detail, by provinces, this was:—

Prince Edward Island.....	\$ 672,000
Nova Scotia	4,085,000
New Brunswick	3,096,000
Quebec	20,330,000
Ontario	20,049,000
Manitoba	4,339,000
Saskatchewan	6,612,000
Alberta	4,747,000
British Columbia	3,864,000
	<hr/>
	\$67,794,000
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An undue proportion of these abatements would fall on the very province least able to bear them. A heavier federal government contribution was inevitable if the system of health insurance was to be soundly financed and put into operation throughout the country. Unless the federal government does contribute heavily, either the contribution would be too heavy a burden on a large number of low-income families, or else the provincial budgets would be required to absorb, through abatements, such a large part of the burden as to be financially impractical.

The recommendation to require only a \$12 annual contribution per adult, plus an addition, according to income, from those in the income tax brackets, would increase the federal government grant from \$40 million to about \$100 million a year, leaving only a reduced administrative cost, and the abatements allowed from the \$12 contribution to be borne by the provinces.

It has been estimated that in 1942 there were about 677,000 single persons in the income tax brackets, and about 1,323,000 married persons. This leaves some six million adults who would be required to pay only the \$12 annual contribution.

It might be mentioned at this point, in answer to questions raised at previous sittings, that the income tax division has no analysis of income tax payers by provinces available at present.

The plan now recommended is largely, but by no means wholly, contributory. In accordance with sound social insurance principles, part of what is now spent by individuals for personal medical needs is paid into a special fund in order to smooth out the average annual cost to all contributors, thus avoiding sudden and, perhaps, crushing expenses. The average cost is not only smoothed out, but reduced. At present Canadians spend about \$242,000,000 a year for personal medical care. The plan recommended passes two-fifths of that amount on to

general federal taxation, thus absorbing most of the cost for those who cannot pay the full contribution themselves, and leaving to the general budgets of the provinces only those abatements necessary in the small \$12 annual contribution.

Keeping in mind the problems of practical administration and expense in such a tremendous undertaking, it was felt desirable to choose a basic contribution low enough not only to avoid numerous abatements, but also to keep heavy costs away from provincial budgets not able to bear them.

It is desirable to stress the contributory feature of a sound scheme of health insurance. The contribution is not taxation because the contribution exceeds the value of health insurance benefits furnished. It is merely the transfer of moneys already spent for medical care to what might be called a fund to stabilize medical expenditures.

Sound social insurance principles require that there be a direct relationship between the amount of contributions collected and the value of benefits. This not only generates a demand for efficient service, but tends to restrain clamour for extravagant expenditures.

It has been suggested that contributions should not be collected from all adults, but only from income tax payers. This plan, it should be pointed out, would more than double the health insurance contribution rates of those who do pay income tax, if the same total is to be collected, and would increase the pressure for exemptions.

Nor would it be social insurance. The part of the cost in excess of the average cost of medical care per adult in Canada would be regarded as direct taxation.

And, what is perhaps equally important, it would fail to set up machinery for collecting contributions from every adult—machinery which would be essential to any contributory old age pension plan.

It has been said that perhaps graded contributions should commence at levels below the present income tax exemptions. This would mean the expensive procedure of requiring income tax returns from individuals not at present required to file them, for the sole purpose of a health insurance contribution.

It has also been suggested that the total cost of medical care should be raised, not by a social insurance contribution from individuals but through general taxation. Such a scheme would not be health insurance—it would be medical relief, and would, necessarily, be subject to the residence and means tests associated with such relief plans.

It should be pointed out that such a relief plan would violate the canons of sound administrative responsibility, in that moneys raised solely by the federal government would be expended by the various provincial governments without direct political responsibility.

The provincial equity in the plan of health insurance is greater than that of the federal government. In fact it is the constitutional responsibility of the provinces. It is for that reason that it is suggested that the contribution collected through the income tax machinery be collected on behalf of the provinces; that is, on behalf of those provinces having a health insurance plan.

It is in part to overcome the difficulties created by having provincial health insurance plans financed substantially from federal funds that it is suggested that the federal contribution should be based on the average cost in all provinces instead of the conventional fractional share of the cost, and that each individual province should bear fully any excess of costs over the average, thereby leaving it with a powerful incentive for economy and efficiency of administration.

As far as the cost of health insurance for children is concerned, if possible this should not fall primarily or solely on those raising the children. It should fall to a large extent on the federal budget, as a sound investment, and to a lesser extent on contributors with above-average incomes.

Health insurance for children would thus be one of the most desirable forms of children's allowances, yielding a valuable return to the nation as a whole both in building better citizens and in lowering the costs of medical attention in later life.

It is in accordance with sound principles, in any case, that the adult contribution should be high enough to include a contribution for children who may, at any time, become dependent on the adult.

It has been suggested that as an alternative to having a supplementary health insurance contribution collected through income tax machinery, it might be desirable to divert or earmark a portion of a somewhat higher general income tax for this and other social insurance purposes, on the ground that the public would regard such addition as tolerable because it knew it was getting some apparent direct return.

It is felt to be better to add a health insurance contribution to be collected through the income tax machinery in addition to the basic \$12 annual contribution, so as to make health insurance more clearly contributory. If contributory old age pensions are desired, the contributions required will be too heavy to earmark out of income tax, and would be required from every adult.

It is not sound social insurance to pay wholly out of taxation what is at present an expenditure for the personal needs of life, as it is obvious that such a technique could not be carried through in the next likely stage in the social security program.

Various studies indicate that individuals in the income tax brackets already spend more on their medical care as their income increases. It is with this fact in mind that a plan is recommended which relates both to their ability to pay and to present expenditures.

The recommendations concerning finances are limited to suggestions for financing health insurance, and not to the financing of an integrated social security program as one part of the whole post-war public finance program. It is felt, however, that they would fit into the machinery required for the larger social insurance contribution, based on income, which would be required if contributory old age pensions were added.

It should be remembered that health insurance is looked upon at present as a post-war plan. In that post-war era, it is generally expected that general taxation, including income tax, will be lower than war-time levels.

It may well be that the tax reductions will exceed the health insurance contributions, thus accomplishing a net reduction which will include all the benefits of a full health insurance plan.

The CHAIRMAN: Thank you, Mr. Stangroom.

Mr. MAYBANK: Mr. Chairman, I did not get the commencement of Mr. Stangroom's memorandum, and I wish to ask a couple of questions. Will he say again the reason for this memorandum being read this morning? Did I understand it to be in answer to certain questions?

The CHAIRMAN: Yes.

Mr. MAYBANK: Are these the answers of a departmental committee?

The CHAIRMAN: I understand so.

Mr. MAYBANK: I just missed something at the beginning. I wanted to understand a little better the whys and the wherefores of this.

Mr. STANGROOM: These questions were directed to us, Mr. Chairman.

Mr. MAYBANK: Directed to you by the committee last time?

Mr. STANGROOM: Yes.

Mr. MAYBANK: And these are the answers?

Mr. STANGROOM: We answered the questions this morning.

The CHAIRMAN: You are answering for the finance committee?

Mr. STANGROOM: Yes, in the light of our previous reports.

Mr. WOOD: I notice you mentioned earmarking certain types of income taxation. What difference would it make if you earmarked some of the revenue that goes into the Consolidated Revenue Fund such as I think I suggested at the last meeting regarding those things which have a tendency to impair the health of the nation? Do you understand my question? What difference does it make whether you earmark a certain portion of the income tax particularly for this work or whether you earmark certain revenues from certain sources, like excise tax, and which go to the Consolidated Revenue Fund? There would be no difference, would there?

Mr. STANGROOM: It is felt, Mr. Chairman, that an individual contribution is required if you are going to set up efficient administrative machinery. You cannot identify your individual contribution to the Consolidated Revenue Fund nor could you necessarily identify your direct benefit. But you must have, particularly in a provincial scheme, a tight form of registration of your contributors, because you may have people travelling through your province who are not contributors. You may have American visitors who are not contributors. You must in any case set up such a contributory scheme if you are going to have contributory old age pensions later on.

Mr. HOWDEN: Mr. Chairman, I should like to go back to my question of the other day. I have a hunch, let us say, that the difference of \$2 in this premium will make a very great difference in the attitude of the Canadian people, and to the manner in which this proposal is viewed. I have an idea that if this personal contribution of \$12 were cut to \$10, and that if the difference were made up by raising the income tax level—leaving the floor where it is, but raising it a little bit, as it were—it would make no difference to the middle groups, to the people of mediocre circumstances. We would pay the same amount of health insurance yearly that we are doing now, but it would ease the burden of the tax on the lower income groups, and it would not hurt the higher fellows. I do believe that a \$10 contribution would appeal to a very great many people much more than the \$12 premium.

Mr. McCANN: Do you mean raising the rate or including more people in it?

Mr. HOWDEN: Including more people in it. That is it. Not raising the rate.

Mr. McCANN: Mr. Chairman, I think that we are losing a great deal of time here until we decide definitely whether this is going to be a contributory scheme or not. I think that is the main principle and it ought to be decided by the committee at this time. If it is a contributory scheme you are going to take more people who are directly interested in it and there will be less strain upon public funds if you have a contributory scheme in operation than you will have if you have a scheme fully paid by the state. The matter of the amount of the contribution can be decided later, but we should decide, having regard to the advice which will be given to us by financial advisers upon this matter. I think I can say for every doctor upon the committee that if this is not a contributory scheme then I might as well withdraw from this committee, and that is exactly what I would do; because if it is not a contributory scheme you put this country immediately into state medicine, and there is not a doctor in the whole country who wants to serve the state under those conditions.

Mr. MAYBANK: Do you mean wholly contributory?

Mr. McCANN: No, not wholly; but it has been suggested that it would not be contributory at all. I think the committee ought to decide what its state of mind is and what it wants to determine as regards the principle and decide that very very clearly; and if we are going to have a contributory

scheme let the committee endorse it, if it is not going to be a contributory scheme let us say so. As I say, it will not meet with the approval of any medical member upon the committee or any doctor in the country.

With regard to the amount of the contribution we would be justified in taking the advice of the financial advisers because they know exactly—or they know better than we do at any rate—what the financial condition of the country is likely able to bear.

Mr. HOWDEN: Let us make this clear: your exception is based on the fact that if the country were to adopt state medicine medical men would be put on a salary basis, is not that so?

Mr. McCANN: Yes. I do not think they would want to operate on that basis. That is my personal objection, and that is the objection that I hear from the profession as a whole.

Mr. BREITHAUP: Mr. Chairman, there was a motion passed at our last meeting which was moved by Mr. Cote and which, I think, covers the point. I quite agree with Dr. McCann.

Mr. BRUCE: Mr. Chairman, I would like to say that I entirely agree with the remarks made by Dr. McCann. It seems to me that in order to facilitate the business this morning we might, perhaps, make a motion at this stage, and I would prefer to divide the motion made by Mr. Cote the other day into two parts: let us deal first of all with the question of whether we will have contributions, and secondly what the amount of the contribution shall be, and thirdly let us deal with the other item in the discussion. I, therefore, move that the principle of the contributory method should be employed.

The CHAIRMAN: Mr. Cote made a motion to the committee at our last meeting which was accepted, and I think the proper procedure will be for Mr. Cote to withdraw his motion until the other motion is disposed of.

Mr. DONNELLY: What is Mr. Cote's motion?

The CHAIRMAN: Mr. Cote's motion, Dr. Donnelly, is that subsection (b) of section 2 of this agenda be approved by the committee.

Mr. BREITHAUP: Will you read the original motion?

The CHAIRMAN: "(b) retaining the amount of a contribution of \$12, abolishing collection by means of income tax, and supplementary payment through the national revenue in lieu thereof."

Mr. Cote's motion implies specifically the acceptance of the contributory method.

Mr. COTE: If it is better, I have no objection to withdrawing this motion for the time being in order to clear up the suggestion made by Dr. Bruce.

Mr. BRUCE: We would do it to move this as an amendment.

The CHAIRMAN: No, Mr. Bruce, make it a motion.

Mr. BRUCE: I move then that the principle of contributory insurance be endorsed.

Mr. KINLEY: I would like to ask a question. Do I understand that the people of Canada are paying \$242,000,000 for health services in a general way; now I would like to know what would be the taxation feature; I want to know how much would be the real cost of this scheme?

Mr. CLEAVER: I understand we were to discuss the cost later.

The CHAIRMAN: Mr. Kinley has asked a question which I will ask Mr. Bryce to answer.

Mr. BRYCE: I want to make sure that I understand the question. As I understood Mr. Kinley he suggested that Canadians are already paying these costs in one form or another and the question, therefore, is as to what additional cost is really involved.

Mr. KINLEY: Yes.

Mr. BRYCE: In answer to that question I would emphasize two points. The additional real costs involved would presumably be the greater services, health services, that would be used under this scheme; we would hope that there would be a greater use of health services under the scheme.

Mr. McCANN: Because they would be better distributed?

Mr. BRYCE: Yes, because they would be better distributed. Undoubtedly many people will take advantage of these services on the ground that they are entitled to them whereas before they could not afford them or there was some embarrassment.

Mr. HOWDEN: You might include that all of the services are being paid for now.

Mr. BRYCE: Yes.

Mr. WOOD: Would that include the use of patent medicines, because a lot of money is spent on patent medicines.

Mr. BRYCE: I presume so. The second point is that much of what is now paid privately and directly will be paid through the financial machinery of the government, either in contributions or to the extent of \$100,000,000 under what is proposed to come from the budget. Now, paying it through the budget and through financial contributions will make Canadians more aware that they are paying it, to some degree. It involves certain difficulties, public difficulties, but it does not involve any greater real burden. Now, I would say that the only real burden that might be involved in this point, whatever real burden there is, arises out of the effects of taxation and the effects of making contributions.

Mr. KINLEY: There are two figures, the \$242,000,000 and the estimate of what this scheme will cost the people of Canada. I want to know the difference between the two.

Mr. McCANN: The report says \$250,000,000.

Mr. BRYCE: I believe it is true to say that the estimate of the cost of the scheme is based primarily upon the estimate of what is now being paid for health services.

Mr. KINLEY: What is the figure?

Mr. BRYCE: That figure as Mr. Stangroom put it this morning was \$242,000,000.

Mr. KINLEY: That is what they are already paying?

Mr. BRYCE: I do not want to appear to be stating too accurate a figure. We used a figure of about \$250,000,000 in our report, but it was based on the same essential information.

Mr. KINLEY: That is the difference between the two ideas. That is, they are paying that much now and if they take on this contributory service they would only pay \$10,000,000 more?

Mr. BRYCE: Yes.

Mr. KINLEY: There is only \$10,000,000 taxation involved?

Mr. BRYCE: New taxation.

Mr. FULFORD: I received a resolution which was passed unanimously by the Medical Association of the entire counties of Leeds and Grenville protesting vehemently against the principle of compulsory health insurance, and I feel obliged to go on record in that regard.

Dr. HEAGERTY: I might point out that the Canadian Medical Association sent a questionnaire to the doctors of Canada some time ago and received replies which would indicate that a very large percentage—probably more than 50 per cent of the doctors of Canada—favour health insurance.

Mr. COTE: Could we hear the motion again?

Mr. BRUCE: May I say a word to supplement the statement made by Dr. Heagerty and to answer the statement made by Mr. Fulford with regard to the resolution which was adopted by the medical association in his constituency. I have met groups of medical men and I think the reason that a certain amount of opposition has emerged from the doctors to this measure of health insurance is that they do not understand it. At this time more than any other time doctors are very busy. They start in early in the morning and they are kept going until midnight and after, and they really are not informed in a general way as to what it is intended to do with this health insurance. I might add that when I explained health insurance to small groups of doctors and when I explained what the intention is I found that I changed them in a very few minutes from an attitude of opposition to one of saying: Well I guess it's all right.

The CHAIRMAN: The motion is that the contributory principle of health insurance be adopted.

Mr. COTE: Perhaps this motion could be supplemented. I think Dr. Bruce has not in mind to have this committee endorse the principle of entire contributions. If he would include in his motion the principle of partial contributions that would meet our views very nearly.

The CHAIRMAN: I think that is implied.

Mr. COTE: Is it?

The CHAIRMAN: The contributory principle.

Mr. LALONDE: Just in principle.

The CHAIRMAN: It may be one per cent or 10 per cent or 50 per cent.

Mr. CLEAVER: Mr. Chairman, I wonder if either you or Dr. McCann would enlighten me on a point. I understand Dr. McCann to say that in adopting the contributory feature we were more or less impliedly determining either the amount or the mode of remuneration of the doctors.

The CHAIRMAN: No, no, not at all.

Mr. CLEAVER: Well, I understood that a moment ago; that if the contributory feature, to which the doctors were not opposed, were not adopted they would withdraw. I would like that point amplified. I cannot understand the position that is developing. Should we decide upon a non-contributory scheme? As far as I am concerned I favour the contributory scheme, but I cannot understand this opposition.

Mr. McCANN: The idea of the profession is that you can have two types: you can either have a system of health insurance or you can have a system of state medicine. The contributory system in my judgment assures a system whereby everybody who is making a contribution will be interested in it, and probably the best way to put it is that those people who make contributions to the cost of providing benefits are more likely to help in cutting down unnecessary demands upon the fund.

Mr. CLEAVER: I understand it now.

Mr. MACINNIS: Mr. Chairman, I understand that the motion is that we decide on the means of financing this scheme, and that it will be partly by contributions from individuals. Personally, I have no objection to a contributory scheme. As a matter of fact I favour a contributory scheme, because I believe that if the individual knows and understands that he is contributing to any particular venture he has more interest in it because of that fact and it raises his status, I believe, in his own estimation. But I think that something else must go along with that in order that the contributor may be more than merely a contributor and possibly a beneficiary under this scheme. And in that regard I believe that there is considerable to the question asked by Mr. Cleaver; because if I understand what Dr. McCann said aright the relationship of the doctors to the scheme will depend on whether they are going to be on pretty much the present basis excepting that they will be assured of their income for whatever services they give. Now, if we are going to have a contributory scheme—and I am in favour of a contributory scheme—there also must be provision made for the contributors to have some say in the organization and the administration of the scheme.

Mr. McCANN: Don't you think that is provided for?

Mr. MACINNIS: I am not so sure. As a matter of fact that is what I find to be in the minds of the people with whom I come in contact; they say that if this is going to be a scheme that is to be exclusively controlled by the doctors they are not for it. Now, I think when a doctor says he is opposed to any plan of this kind, any social plan for state medicine, he considers that the ill health of the people is raw material out of which he is going to make an income.

Mr. McCANN: Oh, no.

Mr. HOWDEN: That is not the idea.

Mr. MACINNIS: That is an idea which has been put over to the mass of the people who will be contributors under this scheme. I am speaking of the kind of people I know and meet.

Mr. MAYBANK: Are you sure you are not planting a seed?

Mr. MACINNIS: No, I am not planting a seed at all, and if my friend had been at the meeting when the representatives of labour were here last year and made their presentation with regard to this plan he would know quite clearly that I am not planting a seed.

Then again the amount of the contribution is of the utmost importance. The amount of the contribution will have to be such that the ordinary individual who comes under the scheme will be able to pay it with some reasonable ease, and I was very glad to hear Mr. Stangroom make his statement this morning. I mentioned this the other day, and I am trying to get this point over because I think it will indicate my own sincerity and my own feelings in the matter, that it is important to get over the idea that the contribution is not taxation in the ordinary sense at all because the contributions, as far as the great mass of the people are concerned, will be less than the benefits received. I think that matter is of the utmost importance to get across to the people in order that the contributory scheme will be more readily accepted by those who are getting very small incomes.

Just one further word, and that is with regard to the point mentioned in the first brief prepared by the advisory committee—when the income of 62 per cent of our people is less than \$950 a year we can readily understand how small the income of many in that 62 per cent really is.

Mr. BREITHAUP: That was away back; that was not an up-to-date figure.

Mr. MACINNIS: That was 1941, and it is very close.

Mr. WOOD: There would be a lot of other perquisites; you include the farmer and he gets a lot of his revenue besides that.

Mr. MACINNIS: I quite understand that, but the farmer never says that when he is putting up a case for the farmers.

Mr. WOOD: You have to state the facts.

Mr. MACINNIS: My point in relation to the contribution is that all of this will have to be financed out of the national income, and those who receive the larger share of the national income must pay a larger share of the shot which it takes to finance this scheme. If people get too little of the national income you cannot ask that they pay a little more out of the very little that they get. If the distribution of the national income is equalized or more nearly equalized then the fact of the contribution will become of very little importance because it will be paid out of the national income and it will be paid by those who receive the national income. The whole trouble now is that too many receive too little and a few receive too much of the national income.

Mr. HOWDEN: Mr. Chairman, there does not need to be any ambiguity with regard to the attitude of medical men. That attitude ought to be stated in plain words so there will be no question about it at all. There is a certain number of medical men in Canada; they are all well disposed one toward another and they want to see each other live; they do not want to see a scheme brought in by which a certain number of doctors are put on a salary basis and the others allowed to shift for themselves. That is the whole story as far as I can see, and I think they are entirely right. The medical men are standing out for a fee basis in this bill, the same basis as they work on now, and we will take a chance on it, but if a certain number of medical men are put on a salary basis and the rest excluded, then God help us. Now the medical men are merely looking after themselves in a proper way.

Mr. WOOD: This would seem to be a field day for medical men, but I believe one thing that is confusing the mind of a lot of people, and my attention has been drawn to it on several occasions, and I believe that this is the proper place to bring it up, is something like this: in a book published by Miss Charlotte Whitton, entitled, I think, "The Dawn of an Ampler Life", which is more or less a resume of the social security plan—I am sorry I have not the book with me at the present time—there is a statement made there by her to the effect that the average income of the doctors in the Dominion of Canada at the present time, taking the number of doctors and the amount received by them, is \$3,000 and under this scheme if they all share and share alike in this scheme the average income will be \$10,000.

An Hon. MEMBER: Oh, no.

An Hon. MEMBER: That is false.

Mr. WOOD: I do not know whether it is false or not but the statement appears in that book, and I mention that fact. I notice the confusion of this committee and it is exactly the confusion of the public if this is a case of saying: This is a good scheme for the doctors; where do the benefits to society come in? I think that ought to be analysed and if these facts are true we should know and if they are not true I think that this committee should know. I must admit that I was astounded when I discovered that. There are some other matters in relation to that which I will speak of later.

The CHAIRMAN: Mr. Wood, are you quoting that book as an authoritative statement?

Mr. WOOD: This is a book that has had a certain amount of popularity; like many other books it may be sound or it may not.

The CHAIRMAN: Are you putting that on record as an authoritative statement?

Mr. JOHNSTON: I think that statement was made—I forget the name of the lady who made the investigation for Mr. Bracken.

Mr. HEAGERTY: Mr. Chairman, the statement of Miss Whitton is erroneous. If you go back to 1931 you will find the figure for the decennial census in that year as gross income for physicians was \$5,237; so if Miss Whitton is wrong in that statement it is quite possible she may be wrong in other statements.

Mr. WRIGHT: It seems to me that we are arguing something which does not come within our reference to this committee. That part of the bill is up to the provinces; they will decide as to whether the doctors will be paid under the bill. I do not see why this committee should waste its time discussing this matter. There is enough to decide here about this bill without going out and giving advice to the provinces who will probably do what they like with respect to this matter anyway.

Mr. CLEAVER: Mr. Chairman, I would like to take up one point at a time. As I understand the matter before the chair now, we are trying to reach a decision as to whether any part of the cost of the scheme is to be contributory. According to the manner in which the motion is now drafted no part is implied. I think the motion should include the actual words "in part". I believe that is the intention.

Mr. BRUCE: Yes, that is my intention and I have no objection to those words being included.

The CHAIRMAN: Your motion would then read: "That the contributory principle of health insurance, in part, be adopted".

Mr. COTE: That would be better.

Mr. CLEAVER: If that is our intention, why not say it?

Mr. BRUCE: I have no objection to those words being inserted.

Mr. LECLERC: Dr. McCann mentioned that the contributory system would lessen the number of our unnecessary calls. I am afraid that there would be a lot of unnecessary calls under one system or the other.

Mr. McCANN: Take the case of a man with a family who is contributing for himself, his wife and two or three children \$50 a year under this scheme. If he is a sensible man he will say that under this scheme there is a certain aggregate amount of money and that if he and his family and 100,000 other families in the country are going to send for a doctor every time that one of the children has a headache or some minor complaint the aggregate cost of this service must go up; if, on the other hand, he is a contributor to it he will exercise the same good common sense which he has probably exercised in former years when he has had to pay for that individually out of his own pocket.

Mr. JOHNSTON: Does that always follow? I do not agree with Dr. McCann's statement, and I might take the exact opposite view. I could take the same illustration which was used by Dr. McCann. Here is a man who is paying \$50 or \$100 a year for medicine; his child has an in-grown toenail, and that man says: We are paying for this service a matter of \$100 a year, and we will go to the doctor. I do not think for a moment that if this were going to be a non-contributory scheme it would induce people to go to the doctor more readily than ordinarily. On the other hand, if this is a national affair, and it is supposed to be, for the health of the people, and if a child has an in-grown toenail he should go to the doctor. I do not see any objection to that at all. May I say with regard to the statement made by Mr. Wood that I saw a reference to that in a newspaper and I think I have it on file.

The CHAIRMAN: Pardon me, that book is not in evidence at the moment and I do not think we can discuss it.

Mr. JOHNSTON: I am not saying that it is in evidence; I say that I saw the article in the press.

The CHAIRMAN: So did I.

Mr. JOHNSTON: Now, the chairman has contradicted that and he seems to be quite determined about it. Be that as it may, I think we should have some special evidence before this committee to ascertain what the average income of the doctors was and what it will be when this scheme is put into force. There is quite an opinion abroad that the doctors are going to make a very good thing out of this. I am not here to say that they are not. But I think that we should have the matter cleared up and some evidence put on record by Dr. Heagerty, the chairman or somebody else, to show exactly what the incomes will be.

Some Hon. MEMBERS: Question.

The CHAIRMAN: Mr. Kinley.

Mr. KINLEY: It seems to me that this resolution rather begs the question. In all our discussion here, it would seem to me that it was self-evident that any scheme of insurance would be contributory. I thought that was axiomatic. I am not just sure what the resolution says, but if it mentions the scheme, I bring it to your attention that there is not any scheme. We have not adopted any scheme.

The CHAIRMAN: It does not mention any scheme.

Mr. KINLEY: Would you read it?

The CHAIRMAN: The motion reads as follows: "That the committee approve the principle that the cost of the plan be on a contributory basis."

Mr. KINLEY: The plan?

The CHAIRMAN: The plan of health insurance, if you wish.

Some Hon. MEMBERS: Question.

Mr. JOHNSTON: Mr. Chairman—

The CHAIRMAN: Mr. Maybank.

Mr. MAYBANK: I think that one or two speakers went too far afield. This is a very simple resolution at the moment.

Mr. JOHNSTON: It is very complicated.

Mr. MAYBANK: Surely not at this point. I think the complication is being introduced. I think Dr. McCann himself is to blame for introducing a complication between him and Bow River. He and I have since agreed that if he had said dandruff instead of ingrown toenails, there would not have been any dispute. He says he can think of milder diseases than these. If so, he should have mentioned them, and not got into that very complicated medical field.

It does seem to me that we do not have to determine any of these other questions upon which we have been speaking at this moment. It is true that when a person votes, shall we say, in favour of the contributory principle at this moment, he has reserved in his mind a number of points; for example, the question as to whether this scheme will afterwards be run wholly by the doctors for their own benefit or whether others will be administering the Act, or such things as that. They will all come up in due course. Now all we need to determine is just the general principle, do we think it is a good idea for people to make a direct contribution, without even stating the amount. I submit, sir, that we should, in justice to ourselves, vote on that question now.

Some Hon. MEMBERS: Question.

The CHAIRMAN: Dr. Donnelly.

Mr. DONNELLY: I just want to say, as far as I personally am concerned, that I am in favour of a contributory scheme of health insurance. I think that all our social legislation—old age pensions as well—should be made contributory. People do not appreciate something that they can get for nothing. If they contribute to it, they feel they have bought it, have paid for it and are entitled to it. It leaves a much better taste in their mouths, they feel better for it and they are better for it. Referring to some of the discussion that took

place here a moment ago with regard to the doctors being run to death over this, may I say I have had the experience of practicing in municipalities where we are paid entirely by the municipality for health insurance. For all that we do, we are paid a salary and the patient gets his attention for nothing. He may call the doctor in, he may come to the doctor's office or the hospital, and he gets his treatment for nothing. I want to say that it is very, very satisfactory. The people are satisfied with it. The doctors are satisfied with it. We do not want to change from the scheme we have in those districts right now. Some of those municipalities that I practised in have charged \$2 for the first call in order to prevent people from taking advantage of it and asking the doctors to come when they are not needed. One of them I practised in charged \$1. Two others charged nothing. I could not see a bit of difference in any one of them—not a bit. In all cases they were satisfactory. The people do not come in and ask the doctor for work. Of course, a lot depends on the doctor himself. The doctor may discuss what is wrong and so on, investigate before he goes out, and say, "Well, bring the patient in to the hospital and I will see him." But there is no difficulty in that respect at all. We have found that our people in the province of Saskatchewan who have municipal doctors are absolutely wedded to the scheme and want nothing different from that. I think that any health insurance scheme that we have should be made contributory, whatever the amount may be. I would say that. Whether it should be more or less than \$12, I am not saying. But I believe that the people themselves should contribute something towards it.

Mr. McIVOR: Mr. Chairman, from my experience in discussing this question since 1935 with farmers, I would say their feeling is that they want to contribute something. It is just like a man who does not want anybody else to pay his board. He wants to pay for his own eats. But I agree with Dr. Howden that \$10 would be better than \$12. I am putting myself in the place of a farmer now. As far as the administration of the Act is concerned, it would be by a commission and the chairman of that commission shall be a doctor of medicine; it says not "must be" but "shall be", which is pretty nearly the same thing. I notice too that all the commission will not be doctors. I think, as I look upon this commission, that it would be fairly reasonable. But my own point is that no man who has the calibre of manhood in him wants anybody else to pay for his sick wife, his family or himself. Therefore I think we should have a contributory scheme. But I agree with Mr. MacInnis in the other way as well.

Mr. McCANN: Mr. Chairman, I just wanted to ask Dr. Donnelly a question with reference to municipal doctors in Saskatchewan. Is it not a fact that each man pays a land tax for that specific purpose? And if so, is not that his contribution towards it?

Mr. DONNELLY: Some of them do. You must understand in this case that the landowner does. It is all collected in taxes. For example, speaking of myself, I have a renter on my farm. My renter on the farm does not pay a nickel. I pay it all, because I pay the taxes.

Mr. McCANN: Does he not pay rent?

Mr. DONNELLY: No. His rent is one-third of the crop. It is crop rent. But he does not pay anything in the taxes. I pay all the taxes. As a matter of fact, that is the system that we have in Saskatchewan of renting. But the renter pays nothing. The man who owns the farm pays all the taxes. He pays the municipal doctor.

Some Hon. MEMBERS: Motion.

Mr. KINLEY: Can we proceed with the motion?

The CHAIRMAN: Order, please.

Mr. JOHNSTON: Before this thing is put to a vote, I should like to say this. When we speak of a non-contributory plan, I think most people have that confused. It must not be understood that, if we introduce a non-contributory form of health insurance, the people themselves are not going to pay for, that they are going to get something for nothing. I think Mr. McIvor's analysis of this thing is all wrong, because you do not want to assume for a moment that the people are not going to pay. If it is coming out of the national revenue, it is not going to be something for nothing.

Mr. COTÉ: It is a psychological thing.

Mr. JOHNSTON: No, it is not a psychological thing at all. Dr. Howden has killed that argument entirely. It seems to me that in this national revenue everybody pays. It might be said that a person with an income of under \$660 will not pay; but he does, because he has to pay for the goods which he buys from industry, and industry pays its share. Those people in the income tax brackets pay their share. So everybody all the way down the line pays for this thing. It is not something for nothing. I want to put myself on record here as being against a contributory plan. I think that the proper thing would be a non-contributory plan. When it comes to this amendment, I would much rather see something such as Dr. Heagerty suggested, that we make it a \$12 fee and the rest come out of the general revenue. This thing we have before us now is very vague.

Mr. CLEAVER: We decide the amount later.

The CHAIRMAN: It is very complete.

Mr. CLEAVER: It is the general principle.

Mr. JOHNSTON: I am against the principle, anyway.

Some Hon. MEMBERS: Question.

Mr. LOCKHART: Mr. Chairman, when we get the conversational hazard dispensed with a little, perhaps I can be heard. I understood Dr. Heagerty to say that there was considerable objection, by medical groups throughout the country, to this scheme; and Dr. Bruce supplemented that by saying that the doctors did not understand the scheme, and that was the reason there was considerable objection. I want that point cleared up.

Dr. HEAGERTY: No. That is quite incorrect. I said that the Canadian Medical Association had sent out a questionnaire to the members.

Mr. LECLERC: All of them?

Dr. HEAGERTY: All of those who were members at the time, which I believe would represent about 7,000 of them.

Mr. LOCKHART: What percentage are members?

Dr. HEAGERTY: As I was about to say, about 7,000 at that time of the 11,000 practising doctors in Canada; and all of them expressed themselves as being in favour. The only points of disagreement in so far as the doctors are concerned, or that may arise, is in connection with the method of payment—on a salary basis, a capitation basis or a fee basis and in regard to the reduction of the standard of the practice of medicine. The doctors want no interference between themselves and their patients. They fear that, under a state medicine scheme, there will be such interference. The state may step in between the doctor and his patient, and the state may keep records of the patients. They fear the same type of practice of medicine that prevails in Russia in particular. We had Dr. Sigerist here not very long ago and at a luncheon he lauded the system of health centres in Russia. I asked him if the records that were maintained in those health centres, the records of the patients, were available to the state; and he told me that they were. That is the sort of thing that the doctors object to. The doctors

are not anxious to play a sole or exclusive part in administration. As the bill indicates to you, all parties are represented, and one of the chief reasons that they are so represented is because they are making a contribution.

Mr. LOCKHART: What was Dr. Bruce's reference when he said that the doctors did not understand the scheme and that was the reason why there was considerable opposition?

Hon. Mr. BRUCE: No. I am sorry if I did not make myself clear. I was only supplementing what Dr. Heagerty had said when he indicated that more than 52 per cent of the doctors had agreed to some form of national health service. Then Mr. Fulford presented a resolution, from a certain group of doctors, protesting against this scheme. What I said was in answer to that. I wished to indicate that while a certain number of doctors had expressed themselves as opposed to the scheme, in my opinion it was because they did not understand what the scheme meant; that is all. They thought it was state medicine, and it is not state medicine but health insurance. They are definitely opposed to state medicine. But I am sure that many of these doctors, if it were explained to them that this was a form of insurance, would withdraw their objection to it.

Mr. LOCKHART: We are being asked to vote on a resolution to adopt the principle. Dr. Heagerty has indicated that 7,000 out of 11,000 doctors have expressed an opinion; that is, only the members of the medical association. That means that there are 4,000 doctors who have not expressed an opinion there. Then Dr. Bruce states that the thing is not understood throughout the medical fraternity and for that reason there has been considerable opposition to it. It seems to me we are voting on something that is very vague, although I want to definitely put myself on record as being in favour of some kind of contributory scheme for, Mr. Chairman, as you say, the plan.

The CHAIRMAN: This plan before you.

Mr. LOCKHART: On the assumption that the plan will be finally developed at some future time as and when the conference is held by those who will probably administer it.

The CHAIRMAN: That is right.

Mr. LOCKHART: So in principle I am in favour of a contributory scheme; but I am rather disturbed by the fact that a great percentage of the medical men have apparently expressed disagreement, and Mr. Fulford has even expressed the disagreement of a medical association of two counties. I say we are rather groping around in the dark here when we vote on a resolution of this kind.

The CHAIRMAN: No.

Mr. LOCKHART: I just want to point that out very definitely.

Dr. HEAGERTY: Mr. Chairman, at the very outset the advisory committee on health insurance asked the Canadian Medical Association to form a health insurance committee. That association did so. That committee sat with the advisory committee on health insurance again and again. Subsequently the Canadian Medical Association, for the first time in seventy-five years, met between annual meetings here in this city and passed a resolution recommending the principle of health insurance. That expressed the views of all of the members of the profession in Canada.

Mr. JOHNSTON: May I ask Dr. Heagerty what percentage of the doctors in Canada belong to the Canadian Medical Association?

Dr. HEAGERTY: Since the discussion of health insurance has come along, it has increased the membership very materially; so that I cannot say at the present moment, out of the 11,000 doctors in Canada who are practising, how many belong. But I would say that the number is somewhere in the neighbourhood of 8,000 or 8,500.

Mr. JOHNSTON: Would I be correct in saying—it runs in my mind that I saw it in the *Medical Journal* not very long ago, about a year ago—that there were somewhere around 28 per cent of the doctors who belonged to the Canadian Medical Association? That would be before this health insurance came up.

Hon. Mr. BRUCE: Much more than that.

Dr. HEAGERTY: The figure has always been higher than that. It has usually been in the neighbourhood of 50 per cent.

Mr. VENIOT: Might I, as a member of the executive of the Canadian Medical Association for many years, make the statement that the number of doctors who are members of the Canadian Medical Association is at the present time over 6,000, as compared with a total of 12,000. That is over 50 per cent.

Mr. JOHNSTON: Have we got the figures?

Mr. VENIOT: I can get the figures. I have them in my desk upstairs. We had a meeting of the executive of the Canadian Medical Association here two weeks ago, and those figures were given. But the trouble at the present time is that our membership is reduced because a great many doctors are overseas. There are 3,800 doctors at the present time who are in the armed forces and who, because of that fact, are not active members of the Canadian Medical Association. That condition has prevailed since the war started. Confirming what Dr. Heagerty said, I may say that since the problem of health insurance has been under discussion a greater number of doctors have entered the Canadian Medical Association because they wanted to be informed through the channels of the Canadian Medical Association of what was taking place in the way of health insurance.

Coming to the point raised by a couple of the speakers before me concerning the opposition of doctors to the principle of health insurance, may I say that it was my privilege just before the session opened to speak to three bodies of doctors in the province of New Brunswick, some of whom had registered opposition to the principle of health insurance. Their reason for registering this opposition was due to the fact that they had the misapprehension that health insurance meant state medicine, which is not the same thing at all. State medicine means the regimentation of all the doctors of the country as servants of the country at a fixed salary, under the obligation of treating patients if and when the patients present themselves to the doctor's office, or when they are called.

Mr. LOCKHART: Has that point been cleared up?

Mr. VENIOT: That has not been cleared up.

Mr. LOCKHART: That is the thing.

Mr. VENIOT: That is the unfortunate part.

Mr. LOCKHART: Yes.

Mr. VENIOT: As a result of the very fact that I, for instance, explained to my colleagues in the province of New Brunswick the difference between health insurance and state medicine, they hopped right in on the spot. They realized that what the present health proposals mean is not state medicine but a form of health insurance that will provide to the greatest possible number of people in Canada the best possible medical services. That is what we, as the Canadian Medical Association in Canada, advocate. It is not in our interest or in my interest as a practising physician, to be practising under health insurance at all, whether it be under a salary basis or a fee for service basis. If I am paid on a fee for service basis, I have to hire a bookkeeper to keep my accounts. I cannot do it myself, if I am a busy physician. Why? Because every time a patient comes into my office, a record must be made of that and at the end of the month every account that patients have incurred for my services must be sent in duplicate or triplicate to the government or to the commission which has charge of that.

Instead of having daily payments made to me for my services, I have to wait for perhaps two, three or four weeks for my government cheque, so that I am deprived as a doctor—

Mr. BREITHAUPT: And maybe never get it.

Mr. VENIOT: I do not think that I would never get it, but I would have to wait for it, in the same way as we have to wait for payment in the cases which I and other doctors treat under the Workmen's Compensation Act. I have seen myself obliged to wait two or three months before being paid.

Mr. BREITHAUPT: That is a provincial matter.

Mr. VENIOT: Even so. This is going to be a provincial matter, too. So that the doctors individually are really opposed to any form of health insurance. But as a body which has been on record for centuries as helping the people to regain their health, and who have not been shysters—we have not the reputation of being shysters as some people have—it is a body of the type, I think, that should have something to say in this, and we have to protect ourselves. Let me give you an example. During the depression period I can name you dozens and dozens of doctors whose income during that entire period was less than one-third of what they received prior to the direct relief scheme entering into force. I can give you my own instance, and I can cite the figures that in the year 1933 my income was \$2,600 instead of \$12,000, and my taxes for that year were \$628. So that I had to work for three months for the privilege of practising medicine in my own town. That does not apply to me alone. It applies to every doctor all over Canada. We figured it out in New Brunswick—and we might as well clear this up—that with 250 doctors practising, taking an average of \$3,000 a year, including country doctors and city doctors, there resulted an income payable to the doctors of \$750,000 a year.

Mr. McIVOR: Is that after expenses?

Mr. VENIOT: No. That was gross. During the depression period there was not one single doctor who did not do at least \$3,000 of work for people on relief, for which he did not receive one cent. Therefore the doctors of our province, the province of New Brunswick, gave directly to the people of Canada services to the extent of \$750,000 a year. Therefore, when somebody gets up in this or any other gathering and says that the doctors are shysters and are trying to bleed the people, that is contrary to the facts. There is not a doctor in this gathering who does not do at least \$1,000 of work each year for which he does not receive a single cent. Hence I believe I am justified in making these remarks in defence of the medical profession and in answer to uncalled-for slurs—probably I should not say slurs but rather uncalled-for remarks. Reflections have been made on the medical profession, and I am glad to have had this opportunity of correcting this misunderstanding.

As far as the Canadian Medical Association being a body which dealt with the health insurance problem or studied it, I should like to say that there is only one single national body in Canada which is competent to deal with such a problem because the Canadian Medical Association to-day is made up of nine divisions. It is a national body incorporated by Act of Parliament, made up of nine divisions, one in each province. The British Columbia Medical Society, for instance, is known to-day as the British Columbia Division of the Canadian Medical Association. Every member of that British Columbia Division is also a member of the Canadian Medical Association, the parent body. Each province has a representative on the executive of the Canadian Medical Association, and the executive is composed of a president, a general secretary, a treasurer, a member in charge of the editorial board, plus the elected members from each province. The province of Ontario has two because of its larger population and Quebec has two for the same reason. This executive meets four times a year. They discuss all the problems concerning the medical

profession which are national in scope. The local problems are discussed by the provinces. Any provincial question is discussed by the provinces. But when it comes to a question of national scope like the present one, it is the Canadian Medical Association which deals with it, and it is considered as being the one body in Canada which should be the spokesman for all the doctors of Canada, whether they belong to the association or not. One of the reasons why a large number of doctors do not belong to the association is that they live in out-posts. They can never manage to get to the meetings of the provincial organization.

Mr. HOWDEN: Hear, hear.

Mr. VENIOT: It is not because they are indifferent to medical affairs. Then a large proportion of the doctors are on the retired list. There are some 600 or 700 doctors who are over-age to practise, and therefore are on the retirement list. So that, all things considered, I think that this committee should accept the idea that the Canadian Medical Association is the natural, logical body which should speak for the doctors of Canada.

The CHAIRMAN: Thank you, Mr. Veniot.

Mr. JOHNSTON: I am not going to agree with Dr. Veniot there.

Mr. DONNELLY: He is against it.

Mr. JOHNSTON: Because in the first place, I have been shown a medical book in which it is stated—and I am not going to be dogmatic about the figure; this was about a year ago—that 28 per cent of the total number of doctors in Canada belonged to the Canadian Medical Association. When Dr. Veniot refers to the fact that a great number of doctors do not belong to the Canadian Medical Association because they live away out in the country, that is not true; because I have definitely spoken to a number of doctors who do not live away out in the country or in the bush, and who are not members of the Canadian Medical Association. I am not trying to throw any slurs at the doctors or anything of that nature. I think when information of this kind is given, it should be authentic and it should be substantiated by official records so that people will not have the wrong conception of this thing. I do not think that it is fair for Dr. Veniot to say that anybody attempted to throw slurs, because I do not recall any member of this committee who did such a thing as that. Certainly it was never my intention, and I do not think it was Mr. Wood's intention; and we were about the only two who referred in any respect to it. If he refers to me in that regard, I want to assure him that he was definitely wrong.

Mr. McCANN: I think Mr. Johnston ought to look at the record. The record was put before this committee last year by the Canadian Medical Association and it states definitely and unequivocally the number of doctors there are in the association. Further than that, take, for instance the situation in the United States. Nine per cent of all the doctors in the United States are working for the state or are working in an executive branch of medicine. I would say relatively, having regard to the number of doctors we have in this country, that an equal percentage work for the state. For instance, you have all types of doctors who work for the Compensation Board, for the Department of Pensions and National Health and for insurance companies. The Canadian Medical Association is an association of active practitioners, so that it can be pretty well taken for granted that those men who are in executive positions and are working for the state are not members of the association.

Mr. HATFIELD: What about members of parliament?

Mr. McCANN: I am an active practitioner and I have been for years. Perhaps I am doing too much, but I continue to do a lot of active practice yet,

and I have been an active practitioner and an active member of the Canadian Medical Association for years. May I say that because of the fact that the Canadian Medical Association publishes a journal only in English a large number of doctors of the province of Quebec are not members of the Canadian Medical Association, although a number of them are; but a number of them belong to another organization, the French Medical Association, and that body appeared before this committee last year and put itself on record as being in favour of the principle of health insurance. There are over 2,000 members in the province of Quebec. So when Mr. Johnston makes the statement that only 28 per cent of the doctors of this country belong to the association he makes a statement which is absolutely untrue, and I think, perhaps, he knows it.

Mr. JOHNSTON: Mr. Chairman, Dr. McCann cannot say that.

Mr. McCANN: He should know it.

Mr. JOHNSTON: He is only giving his opinion of this.

Mr. McCANN: I demand my rights here.

Mr. JOHNSTON: You are getting more than your rights.

Mr. McCANN: Mr. Johnston has made a statement which he would know is not in accordance with the fact had he taken the trouble to look up the facts.

Mr. JOHNSTON: That is a statement which is made—

Mr. McCANN: By whom? Bring the statement here and put it on the record. I challenge you to bring the statement here.

Mr. JOHNSTON: Put the official figures on the record.

Mr. McCANN: The figures of the Canadian Medical Association are on the record, and if you would read the record it is there, but the trouble is you do not read the record and half the time you do not know what you are talking about.

Mr. JOHNSTON: Don't tell me what I know.

Mr. McCANN: You do not know what you are talking about because you do not follow the record. Bring your source here and put it on the record.

Mr. JOHNSTON: You are not one of those people who is infallible—

Mr. McCANN: It is on the record and it is there for anyone to see or to read.

The CHAIRMAN: Order, please.

Mr. McCANN: I say that the professional men who are members of the association who have endorsed the principle of health insurance are a great majority of the members of the profession; and let us bear this in mind, Mr. Chairman, that the demand for health insurance under this scheme was not made by the medical profession, the demand for health insurance has been made over the years by the great majority of the people in labour, industry, agriculture—different sections of the country wanted it. Doctors would be in a far better position without health insurance and they would be in an intolerable position with state medicine. But in order to acquiesce in the demands of a great majority of the people of this country the men in the medical profession have decided that they would be in favour of the principle, and at a sacrifice to themselves they want to cooperate with the people of this country in giving them an opportunity to partake of the great benefits which appertain to modern medicine. What has been the difficulty throughout the years? The difficulty has been that medicine has made so many advances within the last 100 years that economically the people of this country have not been in a position to avail themselves of those great advances which have been made. There has been a gap there, and in order to bridge that gap, that social economic gap which lies between the great majority of the people of this

country and the benefits made available to these people economically but which it has not been possible for them to take advantage of heretofore, the medical profession have said that in the interest of a system of health insurance we will pool our resources and give the benefits of modern medicine to the people of this country.

Now, I need not go back over what I have said with reference to contributions. There are a great many people who do not understand the difference between health insurance and state medicine. In an endeavour to explain the meaning of health insurance I gave an address to a number of doctors and I brought forth a definition, and I am going to read it to you: I conceive health insurance to be a plan whereby payments of contributions by or on behalf of a reasonably homogeneous group are made into a common fund and the benefits of such payments are to be distributed to those members and to no others on certain definite conditions, the benefits to be distributed to the patient in money with which he may buy services or in kind in the form of free medical services. Throughout the ages that principle has been followed. Take the case of the guilds which existed at one time in the old country and the guilds which at one time existed in Europe, what have they been doing? They have been contributing into a common fund, and the benefits of those payments were distributed to the members who contributed to the fund and to no others. On certain definite conditions they were distributed to those people in money and in a great many instances the money was paid into an insurance fund. A man was ill and he got so much per week while he was ill and with that money which he received from that common fund he paid for his own medical services. In other cases that benefit was given in kind or in the form of free medical services. That is the type of system which is proposed to be introduced in this country, a system where there will be contributions from everybody and the people who contribute will receive those benefits in kind.

Mr. BRUCE: I have been able to secure a copy of the report of the Committee on Social Security containing the evidence taken on Tuesday, April 6, 1943, when Dr. Routley appeared before this committee for the Canadian Medical Association. In his presentation he stated that there were approximately 10,600 doctors in Canada, 8,500 of whom were English speaking and approximately 2,100 French speaking. Of this total number the Canadian Medical Association has 6,388 members of whom 300 are French speaking. Now, if you take that proportion and deduct the French speaking members from the English speaking members it will give you a proportion of 75 per cent of membership in this association, and the figure is not as stated by Mr. Johnston.

Mr. JOHNSTON: Why deduct the number of French members?

Mr. BRUCE: Because they are not members. It has been explained that the association publishes its journal in English. It is an expensive journal and at the present time it is printed only in English, but I think it is the intention ultimately to issue the journal in French, and I hope that day will not be far distant. At the moment that journal is not published for French speaking Canadians and the French Canadian doctors have their own association in the province of Quebec. That association also appeared before this committee and supported the position of the Canadian Medical Association.

Mr. JOHNSTON: Of course, it is not right, even under those conditions, to exclude all the French doctors, because when we are speaking of doctors in Canada we mean the French doctors of Quebec also.

Mr. BRUCE: I am not excluding the French doctors; we have agreed on this; you are misinterpreting my words.

Mr. JOHNSTON: They are not, as I understand it, members of the Canadian Medical Association.

Mr. BRUCE: No, they are members of the medical association in the province of Quebec but they are supporting the attitude of the Canadian Medical Association.

Mr. JOHNSTON: My question was: What percentage of the doctors in Canada belong to the Canadian Medical Association?

Mr. BRUCE: Even if I include the doctors in French speaking Canada it gives you 10,600 and 6,388 members of this association which is over 50 per cent.

Mr. JOHNSTON: I understood you to say that the figure is approximate.

Mr. BRUCE: No, it is not approximate, it is accurate; it is about 60 per cent of the members of the Canadian Medical Association.

Mr. JOHNSTON: Is not that approximate?

The CHAIRMAN: I would like to point out that a year ago a representative of the Quebec Medical Association appeared before this committee and expressed the approval of his association to this plan.

Mr. DONNELLY: How many doctors were represented?

The CHAIRMAN: Three thousand.

Mr. LOCKHART: I want to vote intelligently on any resolution that is going to be presented, and I would like Mr. Fulford to explain the objection of the medical men in those two counties. They were definitely opposed, as I recall his statement, to compulsory contributions in the form of health insurance.

Mr. FULFORD: When I rose to put myself on record I felt obliged to do so, having received this resolution from the medical associations of the counties of Leeds and Grenville—I felt obliged to present the matter to the meeting. I might say that I have gone to personal expense in sending to doctors in the county of Leeds a copy of the Heagerty report, so I thought that the doctors of the county of Leeds would have had some comprehension of what the idea of health insurance was. I have spoken to doctors individually in my riding, both country doctors and town doctors. It may be as Dr. Veniot and Dr. McCann have explained, that they are ignorant of the present plan, although I cannot see how they can actually be because they have been communicated with by the Canadian Medical Association, of which the vast majority are members. The resolution sent to me was signed by the president of the association. It reads as follows:—

At the last regular meeting of the Ontario Medical Association, Leeds and Grenville Branch, held at Brockville on January 21, a resolution was unanimously passed to the following effect:

That the members of this society are opposed to the scheme of Health Insurance as proposed by the Dominion Government.

Mr. FULFORD: I go on record as being in favour of contributory health insurance.

Mr. LOCKHART: We have heard of a resolution adopted, as Mr. Fulford says, by the medical men of two very active counties in this province, and I think we ought to have that information in order to intelligently vote on a resolution that deals with this plan.

The CHAIRMAN: There is no resolution before the committee from the medical association.

Mr. JOHNSTON: I understood that you were going to wait until Mr. Fulford brought his resolution here.

The CHAIRMAN: The motion is: "That the committee approves the principle that the cost of the health insurance plan be in part on a contributory basis." Shall the motion carry?

Motion agreed to.

Mr. LOCKHART: I cannot vote intelligently until I get the information.

Mr. JOHNSTON: We haven't got all the information. I think we should wait.

Mr. COTE: Before I again put before the committee the motion which I have withdrawn, there is a point that should be made clear. I am in favour of allowing the provinces to take the responsibility of collecting \$12 per capita for adults in their respective provinces. Now, from the draft bill at page 13, section 6, I understand that the provinces will have no authority by themselves to make any abatement or reduction on that \$12 flat rate contribution; they will have to wait until the contributor has made an application for such reduction or abatement and has made out a good case of his inability to pay this contribution of \$12. I would rather leave it to the provinces, giving them a free hand to make an modification on that flat rate of \$12 for adults as long as it brings into the health insurance fund the total amount of \$100,000,000 which represents two-fifths of the total cost of health insurance. They should, I think, have a certain amount of latitude to act by themselves and on their own initiative and to put up, perhaps, a scale of contributions. This might help to meet the views of Dr. Howden and a few other members who believe that \$10 per capita would be more equitable. I would leave that point entirely to the provinces. They should discuss that matter during the coming conference, and we should not touch upon this matter until the conference has taken place.

The CHAIRMAN: I think they would appreciate our expressing an opinion for their guidance.

Mr. COTE: I suggest that this committee would agree on a basis of \$12 per adult per head, but I would suggest that the provinces would be allowed a free hand with regard to this point, as long as they would aggregate the total amount of \$100,000,000 which the health insurance fund will expect through contributions from the provincial organization. So I would slightly modify the motion which I put at first and add that this discussion be left to the provinces as far as fixing the flat rate contribution is concerned, and of course move to abolish all other direct contributions to be imposed by the federal authority, and leave it with the Consolidated Revenue Fund to meet the \$150,000,000 which will be required in addition to the \$100,000,000.

Mr. BRUCE: Mr. Chairman, I have been able to find reference to the attitude of the French Canadian members of the medical profession and perhaps I might be permitted to place it before members of the committee. It is contained in the report of our committee dated April 6, 1943. At this time Dr. Léon Gérin-Lajoie of the University of Montreal was a witness. His authority for appearing here is contained in letters which are translated into the evidence as follows:—

FÉDÉRATION DES SOCIÉTÉS MÉDICALES DE LA PROVINCE DE QUÉBEC

Doctor LÉON GÉRIN-LAJOIE,
1414 Drummond Street,
Montreal, Que.

The Fédération des Sociétés Médicales de la province de Quebec, representing 28 medical societies (with a membership of about 2,000), has formed, with the Collège des Medecins et Chirurgiens and the Canadian Medical Association, a special committee to study the health insurance plan presently before the Canadian House of Commons.

Doctor Léon Gérin-Lajoie is one of the members of this committee to whom we have assigned the task of defending our interests.

Doctor A. M. CHOLETTE,
*President of the Fédération des
Sociétés Médicales*

LE COLLÈGE DES MÉDECINS ET CHIRURGIENS DE LA
PROVINCE DE QUÉBEC

Montreal, April 5, 1943.

Doctor LÉON GÉRIN-LAJOIE
1414 Drummond Street,
Montreal, Que.

My dear Doctor,

The joint committee of which you are a member and which is composed of the representatives of the Collège des Médecins et Chirurgiens, the Fédération des Sociétés Médicales of the province and the Quebec division of the Canadian Medical Association, has studied the question of health insurance and reached the conclusions which you know.

Therefore, I request you, when the discussion of these conclusions takes place in Ottawa before the parliamentary committee to which the health insurance plan has been referred for study, to kindly represent the Collège des Médecins et Chirurgiens de la Province de Quebec.

Trusting that you will be able to render us this service, I remain, dear doctor,

Your very truly,

Dr. J. E. DESROCHERS,
President

There is one clause which I would like to quote from page 155:

Therefore we feel that the Canadian Medical Association, through its representatives here, and myself in particular, approve of this brief twice, through the federation and through the college.

Mr. McIVOR: I understood that amendments with regard to this insurance plan would be brought in, and I have received one this week from the Christian Scientists. According to this they are willing to contribute and they are also willing to submit their patients to medical diagnosis and should illness be established to receive treatment in accordance with the established custom and practice of Christian Science. They are willing to contribute and be diagnosed by a medical practitioner. They are willing to contribute but they want their own practitioners to give service and receive payments. I would like this matter to be considered, although I am not a Christian Scientist nor am I a doctor.

The CHAIRMAN: That matter will be considered when the clauses of the proposed bill are under discussion, and it could be referred to the provinces.

Mr. HOWDEN: I would like to hear Mr. Cote's motion.

Mr. COTE: I may find it difficult to put the motion in satisfactory wording. I would move that a flat contribution rate which will be suggested to the provinces will be on a basis of \$12 per capita per adult per annum, leaving to the provinces the right to modify this basic rate without modifying the total amount which is expected on the flat rate of \$12 per capita.

I do not know if the committee understand my point. This is the second part of the motion; perhaps it would be just as well to make another motion later on.

The CHAIRMAN: That is an expression of opinion on the part of the committee: that in the opinion of the committee the basic rate should be \$12 for adults and that the provinces are free to modify or adjust this rate.

Mr. COTE: And then the latter is important, because in the draft bill the provinces have no discretion unless the individual makes a specific application. The section reads:—"Where the income of a contributor is less than an amount

prescribed, the contribution otherwise payable by him under section 5 of this Act may, upon application, be reduced by such amount as the Commission may determine in accordance with the prescribed regulations."

Mr. DONNELLY: There is the case I was mentioning of the municipality in western Canada where there were 700 people in the municipality over 16 years of age and they would have to collect \$8,400. They can only collect from the individuals \$12 apiece and the municipality can assess for a certain amount and put it on in the form of a tax and as long as they send in \$8,400 that is all we are interested in, and the province can allow the municipality to collect it as they like either in direct taxes on the land or per capita taxes.

Mr. COTE: This motion comes under the motion which Dr. Bruce has put and which has been adopted. This is to remain a scheme of contributory health insurance, so I do not mean to say that the provinces should have discretion to avoid any direct tax for health insurance purposes and put it in their consolidated revenue or general revenue fund. I mean to say that the provinces, if they do agree to that, should have enough latitude to lower the per capita contribution, if they wished to do so or put in operation a scale where some would pay less than \$12 and some would pay more than \$12.

Mr. HOWDEN: So long as the province pays \$12 in the final outcome.

Mr. COTE: That is it; in the final outcome.

Dr. HEAGERTY: This bill does not specify that the province shall pay the sum of \$100,000 a year. It specifies \$12 per capita. If you specify \$100,000 a year you may find that the—

Mr. COTE: \$100,000,000.

Dr. HEAGERTY: Yes, \$100,000,000. If you specify \$100,000,000 a year, you may find that the dominion will have to contribute more and more to the provinces as the population increases.

Mr. COTE: I have avoided mentioning this figure of \$100,000,000 purposely. That is why I say that as long as the provinces provided a total amount which corresponded to a \$12 per capita per adult, that should be satisfactory.

Mr. GUNN: Mr. Chairman, may I make this remark with regard to the suggestion. I think that it is taken care of completely by clause 4, subclause (1) of the Dominion Act.

Hon. Mr. BRUCE: What page is that?

The CHAIRMAN: Page 12.

Mr. GUNN: Page 3 of the Dominion Act.

The CHAIRMAN: Oh, yes.

Mr. GUNN: This draft provision of the bill is only a draft and it is not being put forward to the provinces, as I understand it, as a hard, fast and binding proposal. That proposition is supported by words you will find in clause 4. If I may, I will read that part of the clause, Mr. Chairman:

"The statutory provisions as respects health insurance shall be in such terms as to provide health insurance benefits of the standards, under the conditions and for the classes of persons as set forth in 'A Draft for a Health Insurance Act' in the second schedule to this Act, . . ."

and here are the important words:

"... or substantially in the terms aforesaid."

It does seem to me that by virtue of those words it makes no difference how the province collects the money. They may charge, instead of \$12 per capita, even \$10, \$8 or \$6, so long as the necessary amount of money on the basis of \$12 per capita comes into the fund.

Mr. COTE: That is exactly the point I wanted to touch and put in the motion. That is exactly my view.

The CHAIRMAN: Is it the wish of the committee to defer action on this motion until a later date? I think there is more information we can get meanwhile. The minister is unavoidably absent to-day, and I think it would be well to defer it.

Mr. DONNELLY: It is 1 o'clock. I move that we adjourn.

Mr. BREITHAAPT: Before we adjourn, I notice there is something said in the press about a provincial-dominion conference in connection with this whole matter.

The CHAIRMAN: Yes.

Mr. BREITHAAPT: I should like to ask two questions. Does the chairman know approximately at what time that conference will be held; and when it is held, will the members of this committee be privileged to be present at the sittings?

The CHAIRMAN: I do not know the date, Mr. Breithaupt, but I should think the members of the committee would be privileged to discuss the matter.

Hon. Mr. BRUCE: It will not occur during the recess?

The CHAIRMAN: No.

Mr. JOHNSTON: Before we adjourn, may I ask if the chairman of the committee has received any letters from individuals or organizations to present briefs or to appear before the committee?

The CHAIRMAN: Before you came in, Mr. Johnston, Mr. Wright submitted a brief here on behalf of an organization. That is all. We have had some letters from people not representing organizations, but as individuals.

Mr. JOHNSTON: Did you say not representing organizations?

The CHAIRMAN: Not representing organizations, but as individuals.

Mr. JOHNSTON: Will they be submitted to the committee?

The CHAIRMAN: No, not unless they have something to contribute. Some of them are of a peculiar nature which I do not think the committee would care to look at.

Mr. BRUCE: May I say a word about the report which was submitted on July 23, 1943, the fourth report of the committee which among other things contains clause 2 which states:

That to provide this information officials of the various government departments concerned be instructed to visit the various provinces and to give full details of the proposed legislation to the provincial authorities.

I was wondering if we might take advantage of the Easter recess to give a trip to these gentlemen.

Mr. WOOD: Mr. Chairman, I wish to refer to the question raised by Mr. McIvor concerning the application of Christian Scientists. They really want exemption and they are trying to compromise in the matter, as suggested by Mr. McIvor. I am prepared to take the stand from my own personal conviction that if they want exemption they should have it.

The CHAIRMAN: They have made no representations other than those which they made last year.

Mr. WOOD: I believe they are about to.

The CHAIRMAN: They have made no representations.

Mr. WOOD: That will apply very definitely to the resolution which Mr. Cote has before us.

The CHAIRMAN: May we not discuss this when it is presented?

Mr. MACINNIS: If they have not applied for exemption under the Act it would not affect the financial clauses.

Mr. WOOD: I believe that in the provincial bill which has just passed the Ontario legislature they have been granted exemption, and I am led to believe that in your own province they have been granted exemption.

Mr. MACINNIS: I do not know.

Mr. WOOD: I have that information. To me this means a great deal. I think a man's religious convictions are something that should be preserved.

The CHAIRMAN: When the representations are made to us we will discuss them but we cannot discuss them now.

Mr. JOHNSTON: Is it not true that they did discuss this with Dr. Heagerty?

Dr. HEAGERTY: Yes, we had some discussion and I reported on it. In addition, I have had a telephone communication from Mr. Fulton, the gentleman who presented the brief to the committee. The matter is under consideration by your committee; not by the advisory committee because we cannot take it under consideration at the present time since we are merely acting on your behalf. I wish to point out that there will be a meeting of the Ministers of Health and the Deputy Ministers of Health on the 10th, 11th and 12th of May here in Ottawa, to discuss the details of the bill, and I think that question might be considered then.

Mr. BRUCE: I think that will meet the situation.

Mr. WRIGHT: With respect to the brief I presented, if on reading it members of the committee desire any further information I believe that Dr. Mitchell of the Animal Diseases Research Laboratory in Hull will be available.

The CHAIRMAN: Yes, that was stated in his letter.

The committee adjourned to the call of the chair.

APPENDIX "A"

Brief prepared by the Dominion Veterinary Medical Council to be presented to the National Health Insurance Committee.

The report of the Advisory Committee on Public Health Insurance has created great interest and provoked intense discussion, not only among the professional groups concerned but by the public generally. Much of the discussion has centred around the mode of operation, composition of the committees, and whether or not direction should be undertaken by Provincial Departments of Public Health or by committees appointed, independent of such departments. One group, it would appear, believe medical graduates should be in the majority on any committee appointed, since these are best fitted to determine the type of service which would prove most beneficial to those insured. Other organizations, such as labour and agriculture, feel that since the laity are paying for the service, and are in the vast majority, that they should have the majority on any committee pertaining to the proposed scheme. These points are of importance, and no doubt will have a marked bearing as to the success or failure of the undertaking, but such discussions have perhaps clouded issues which are of more importance.

A review of the report proves it to be exhaustive and informative; it deals at length with administration, financing, scope and benefits, reviews schemes in vogue in other countries, and gives statistics which are interesting. The foreword mentions specific diseases which require attention, such as tuberculosis, in which connection it states: "The control is dependent on a complete preventative service, together with free treatment of all of the people of Canada." Under the heading "Communicable Diseases," it draws attention to the fact that, "Generally, the health of the people in rural areas does not compare favourably with that in urban districts. One of the greatest needs of the present day is the establishment, maintenance and extension of local health services. Since being established in 1926 in the province of Quebec, health units have cut infant mortality in two and have reduced the incidence of tuberculosis and other communicable diseases by about forty per cent. The extension of local health services throughout country districts would have an immediate effect in reducing morbidity and mortality of communicable diseases and maternal and infant mortality. The chief obstacle in adopting public health services in rural areas has been lack of knowledge and lack of funds and, unless financial assistance is afforded, it is doubtful if these services will be provided."

The brilliant results obtained in provinces which have established health units is put forward as a justification for the expenditure of Dominion, provincial and local funds for the provision of such units.

In a study prepared for the Royal Commission on Dominion-Provincial Relations on Public Health, we find the following statement in regard to local health services:

The local health services are the weakest link in the Canada organization of public health. The existing political units of local government are often entirely inadequate as units for health administration. Many are too small to support full-time services for the public health. Staffs, when engaged, consist of part-time health officers who are no doubt competent physicians but untrained in public health. Moreover because of their private interest they are hampered in the enforcement of the law. Part-time sanitary inspectors are usually men without any scientific training whatever. This sort of service cannot begin to apply the achievements of science to the protection of the

health of the people. Furthermore, substantial areas of the country have little health service of any kind. These areas are too poor to attract the private physicians or to set up municipal services.

To those familiar with health problems which directly affect the farmer and other persons residing in rural districts and which, no doubt, contribute greatly to the poorer health of these people, it is disappointing that no recommendation has been made to inaugurate the type of public health service which would benefit this particular group. Although there is, perhaps no aspect of public health which is of more importance to the rural resident than is the control of diseases common to man and lower animals, this phase of public health has not even been mentioned.

Research

It is interesting to note that of the ten conditions listed as requiring further research, six are diseases common to man and domestic or wild animals, and, of course, affect those residing in the rural rather than urban areas.

A great deal of attention has been paid the health of the industrial worker in the past, and it is now suggested that there be supervision of environmental sanitation, medical and nursing services, and all factors relating to health and welfare of industrial workers. It is also recommended that housing plans receive special attention from a health standpoint. The industrial division of the Health League of Canada has developed a plan endorsed by the Federal Government for the improving of the health of the factory worker, that the serious problem of lost time, money and production, because of illness, be reduced to a minimum. It is known that fifty thousand men in Canadian industries are unable to work daily because of sickness, and two hundred thousand people are off work each day throughout the Dominion. Surveys conducted by the industrial hygiene authorities show that this loss, which is due to preventable diseases, costs the workers \$135,000,000 annually, while one and one-half this amount is lost to the employer. The efforts of the Health League are admirable, and no one would deny the factory worker any protection which could be afforded him, but it should be realized that most vocations have their hazards and it would appear from the Health Insurance report that agriculture is no exception.

The report states that by far the greatest number of male deaths in Canada is to be found among farmers, and that nearly fifty per cent of these deaths are in the age group 55 to 64. These figures are highly significant, since the farming population of Canada is 30·8 per cent of the total population and 70 per cent of the rural population. This finding proves very clearly that the agriculturist is subjected to hazards which, although perhaps not so apparent as those common to industry, are real, indeed, and deserving of immediate attention, if the farmer is going to derive any benefit from the proposed health insurance scheme.

As already mentioned, an important problem is the control of animal diseases transmissible to man and, although this aspect of public health is well known, no effort has been made in the past to correct the deplorable conditions which have existed. It is unfortunate that the control of animal diseases has been viewed principally from an economic point of view, with the result that during depression years, when prices were low, these diseases were allowed to go unchecked until now many have become firmly established in our herds and eradication is extremely difficult. Many of these diseases are readily transmissible to man, presenting a health problem the magnitude of which is evidently not realized.

Without minimizing the importance of bovine tuberculosis, which according to many authorities is responsible for almost 75 per cent of crippled children, it can be said truly that other diseases are much more readily transferred to man and may produce conditions as serious.

It is submitted that any "Health Unit" to be effective must include a veterinarian. In meat, dairy and milk inspection, he is the only professional man fully trained and competent by a specialized education to perform this work. Over 70 diseases or conditions of animals are transmissible to man and many of these occur in the herds of Canada—such as infectious abortion of cattle, swine erysipelas, udder infections of dairy cows, equine encephalomyelitis, trichinosis, lymphocytic choriomeningitis, cysticercosis, and bovine tuberculosis. As the causative agents of these infections have their reservoirs in animals, it is self-evident that the veterinarian's place is important in a public health program which takes these conditions into consideration. It would appear the height of folly to organize a Health Unit in rural communities, employ physicians, nurses and sanitary inspectors and at the same time sit down in the midst of potential sources of infection—diseases of animals.

Infectious abortion of cattle and undulant fever in man.

This disease has been recognized as bearing a direct relationship to Public Health for the past 20 years and serious efforts have been made in some provinces to control it but, in most instances, the inspiration for this has been an economic one. That it is a real Public Health problem is shown by the fact that in Saskatchewan, the examination of some 12,000 samples of human blood which had been taken at hospitals for syphilis tests gave reactions which indicated infection with the abortion organism in 4.34 per cent of the cases. Physicians at this time sent in 1,022 samples from patients suspected of having the disease and in this group 67 or 6.5 per cent infected individuals were located. Following the introduction of a plan making it possible for councils to have raw milk herds tested the incidence of infection in the cattle was reduced from 5.68 per cent to 2.58 per cent. It is interesting to note that the incidence of the disease in man, as revealed by blood tests on random samples, was only slightly lower than that in cattle. Furthermore, while the minority of the samples were collected from rural dwellers, the majority of infections were found in this group. Examination of the milk of 60 infected cows showed that 70 per cent of these animals shed the organism constantly or at intervals during their lactation period.

In Ontario it was shown that 119 of 136 cases occurred in dairy and farm workers and rural residents. At that time infection in persons had been reported from 38 of the 44 counties. Examination of the milk of 102 infected cows showed the presence of *Br. abortus* in the milk of 50 per cent of these animals and the percentage would undoubtedly have been higher had repeated tests been made.

Pasteurization protects the urban resident provided all milk and milk products are pasteurized, but the rural dweller is exposed to the danger and the problem remains very much one for the veterinarian.

Swine influenza.

That there is at least a close relationship between this disease and human influenza has received much support so that, apart from the economic aspect, it is important that efforts to control epizootics or enzootics of the disease be continued and strengthened, with further research to clear up the many points, which in common with the human infection, await further clarification.

Swine erysipelas

There is little doubt that swine erysipelas is on the increase in some provinces, where the disease is becoming a major problem. Since man may become infected with this organism, with a resulting condition known as erysipeloid, this disease must also be added to the Public Health list. In European countries, human infections are common. Cases have already been recognized in Canada and examination of human blood suggests that other cases have been unrecognized. In swine there is a decided tendency for the organism to localize in joints

and, with the increase of this infection in those animals, its consideration in connection with some obscure arthritic cases in persons would seem to be indicated.

Tuberculosis

In spite of the unremitting labours of the Dominion Health of Animals Division there are still many herds that have not been tested for this disease and cases of bovine tuberculosis continue to occur in rural children. The tragedy of this is greater in that methods of eradication have been recognized and practised for many years. So much has been spoken and written on this that it is not necessary to labour the point.

Equine encephalomyelitis and encephalitis of man

The first extensive outbreak of equine encephalomyelitis occurred in Western Canada during the summer of 1935 and recurred in 1937, 1938 and 1940. The 1938 epizootic resulted in the loss of some 15,000 horses in Saskatchewan alone. During this time physicians found an increasing amount of human encephalitis. In 1939 the equine virus was isolated from human brains in Saskatchewan and later it was recovered from human spinal fluid in Alberta and confirmation of the identity of the two viruses was also obtained from Manitoba and British Columbia. In 1940, there was a severe outbreak in humans. There were 650 cases in Saskatchewan, which was the worst affected province. This followed a severe outbreak in horses and again it was proved that the equine virus was responsible. The actual reservoir of infection between outbreaks remains to be determined, which fact alone illustrates the need for close collaboration of workers on all aspects of this disease.

The few diseases mentioned do not in any measure cover the field of diseases common to man and animals, and this problem, already great, assumes more formidable proportions every year as new diseases are added to the list. It is clear that a closer association of thought in connection with the diseases of man and the lower animals is of prime importance. Without such association of thought and action any results in Public Health are certain to fall short of the desired goal.

Meat Supply

A great deal has been said as to the future, when all people will have food in abundance, and much has been written about properly balancing diets, that we might not die of starvation unknowingly, but little has been heard as to the quality of the abundant food. No doubt the nutritionalist, and those promising more food and better health, conclude that all food marketed is wholesome. Such a conclusion, unfortunately, is not justified, and until this is realized, and proper adjustments made, the proposed health plan will be built on an insecure foundation. An examination of the existing conditions as far as they apply to the preparation and distribution of meat shows that two very distinct systems are in vogue, one which is good and the other highly unsatisfactory, and in many instances constituting a menace to public health.

Meat sold in Canada falls into two classes—inspected and non-inspected. Government inspected is that killed in licensed abattoirs under sanitary conditions, and inspected before and after slaughter by government-employed veterinary surgeons.

This service is carried out by the Meat Inspection section of the Health of Animals Division, an organization recognized internationally as one of the most efficient in the world. Throughout the Dominion, there are 91 establishments where such examinations are carried out. During the year 1943, a total of 929,157 cattle and 6,140,614 swine were examined. Of the cattle inspected, 11,003 carcasses and 389,281 portions were condemned as unfit for human

consumption. Swine condemnations amount to 12,002 carcasses and 3,559,616 portions. In addition to this, many cities and towns have established meat inspection services under veterinary supervision, and the condemnations made by them would greatly increase the figures already quoted. Nevertheless, there is consumed in Canada to-day an enormous amount of meat which has not been examined by such an inspection service and it is self-evident therefore that no inconsiderable amount of meat offered for sale in this country is unfit for human consumption.

A survey of the meat supply of rural Western Canada reveals conditions of which this country should be ashamed. In marked contrast to the scientific and sanitary system in Government-approved abattoirs, there is in many places an absolute lack of any plan to safeguard the health of consumers, the entire matter being left in the hands of the local butcher, who either buys his animals alive or as dressed carcasses from surrounding farms. If live animals are secured they are slaughtered in the killing house, which is located usually on the outskirts of the town because such places become nuisances during warm weather. These establishments are seldom suitable for the dressing of food animals, although they are preferable to the conditions on the ordinary farm where facilities are altogether lacking and result in meat becoming hopelessly contaminated during the process of dressing.

It should be realized that inferior animals are offered to this market because of deductions made at licensed abattoirs for those poorly finished and unhealthy. Nevertheless it is seldom that any carcass is discarded and parts are only removed when the lesions are too apparent and would be discerned by the eye of the purchaser. Having regard to the number of animals which must be condemned under scientific meat inspection and to the lack of condemnations under the conditions mentioned above, the appalling situation which prevails in many parts of rural Canada can be appreciated.

Milk Supply

Diseases which are commonly referred to as milk-borne are tuberculosis of bovine origin, streptococcic sore throat, staphylococcal food poisoning, undulant fever, scarlet fever, typhoid and paratyphoid fevers. An idea of the significance of these diseases in Canada might be gained from an article by Dr. Defries, published in 1938, wherein he states:

"Through the co-operation of the provincial departments of health, a list of outbreaks of milk-borne diseases, occurring in Canada during recent years, was compiled by the late Mr. R. H. Murray, C.E., and published in 1936. This list recorded 7,935 cases with 688 deaths. Of this number, 7,134 were cases of typhoid and paratyphoid fevers, 584 of septic sore throat, and 192 of scarlet fever. This list records only a small part of the total number of cases of these diseases that had their origin in infected milk. Only the outbreaks that were known to provincial departments of health were possible of inclusion."

He further mentions: "The number of sporadic cases of milk-borne diseases undoubtedly exceeds greatly the number of cases reported in outbreaks. Further, many small outbreaks are not reported; others are not investigated, and in others the possible relationship of the outbreak to milk is not suspected."

A survey of the milk supply of many parts of rural Canada indicates the absence of any system of control which would guarantee a safe supply. In provinces such as Saskatchewan the Health Act makes possible towns and villages passing a By-law rendering it compulsory to have dairy cows tested for tuberculosis and contagious abortion. In this province one hundred and forty-two towns have passed such a By-law. Unfortunately, however, through the lack of adequate veterinary service, seventy-two towns have been unable to have the work done, while fifty have failed to continue with annual tests as provided for in the Act.

That an idea of the quality of milk distributed at country points might be obtained, samples were collected and subjected to qualitative and quantitative bacteriological examination. From the results obtained, it was shown that in most instances the bacterial count was extremely high, while the presence of streptococci and an excess of pus proved that milk from cows suffering from mastitis was being offered for sale.

Too often is it glibly stated that the solution in any community is pasteurization. Such a statement is evading the issue, and is not always practical. Furthermore, pasteurization does not protect the farmer and milk producer, and it was never intended for the purification of pus laden milk from diseased cows. Apart from the actual danger associated with the consumption of raw milk from infected cows, it must be appreciated that such milk, whether pasteurized or not, is probably less nutritious and is undesirable.

To put the matter graphically though unœsthetically it may be said that when a Canadian mother offers her child a glass of milk she should have ample assurance that it was drawn from healthy cows and to this was added the additional protection of pasteurization rather than as is too frequently the case at present that milk is a pasteurized product containing numerous bacteria and appreciable quantities of pus.

It was interesting to note that at public health meetings held recently in Toronto, representatives from Quebec and Ontario, when outlining their proposed plan under the Health Insurance scheme, considered veterinary medicine essential to a sound policy, while those from other provinces, when describing their proposed schemes, did not consider this preventive side and had arranged that the work be carried on by doctors and nurses only. It would appear that even in these enlightened times there is still a tendency to arrange for treatment and provide accommodation for the victims of tomorrow, without taking measures to protect individuals who are healthy to-day.

Considering the role which veterinary medicine should play in the proposed Public Health Insurance scheme, it is unfortunate the profession has no representative committee through which the views of the veterinary hygienist and research worker might be heard on matters pertaining to public health, with which they are familiar. It is realized that provincial committees may appoint veterinary surgeons to carry out health work, but as the proposed act stands the profession is in no position to make suggestions as to what should be undertaken, and how it may be carried out.

Section 45 (Subsection 3) of the report of the Advisory Committee on Health Insurance states:

Recognition by Commission of specially appointed committee of profession organized by statute.

Notwithstanding anything hereinbefore in this section contained, and subject to the next following subsection, if the members of any profession are organized by virtue of a statute of the province applicable to the members of that profession, then the executive body of that organization, under whatever title that body may be styled, shall have power to appoint a committee for the purposes mentioned in subsection one of this section, from the members of that organization, including the members of the said executive body, and the Commission shall, subject to the receipt of evidence of the said appointment, recognize the committee so appointed for such purposes.

Notwithstanding the above, subsection 4 reads as follows:—

Application to dentists and pharmacists only

Unless otherwise prescribed the provisions of the last preceding subsection shall apply only to the members of the dental profession and of the pharmaceutical professions.

It would appear that by some oversight, veterinary medicine has been omitted from the professional groups which might form a committee to be recognized by the Dominion Commission, and it is to be hoped that before the bill comes into being veterinary medicine will be allowed representation, as have the dental and pharmaceutical associations.

The question arises as to the number of veterinary surgeons available for public health work. In this connection, it should be realized that to-day there are insufficient veterinary surgeons to care for the health of our livestock from an economic point of view, a situation which results in tremendous loss to the country each year. This fact naturally turns one's attention to the farmer's lot as far as social security is concerned, and here we find at least one field which, if properly explored and the necessary steps taken to remedy the unsatisfactory conditions existing at the present time, would do much more for the agriculturalist in obtaining that sense of security which is so desired, rather than the palliative measures now in vogue.

The number of veterinarians throughout Canada is insufficient to take care of our needs since there are only 1,200 veterinarians to conduct private practices and man the veterinary services such as the Health of Animals and other Divisions in whose care is placed the health of the enormous live stock population of this country.

Only 46 men graduated from the Ontario Veterinary College last year and this year no more than 20 will qualify. This number will not even take care of the annual vacancies in the Health of Animals or the Pathological Division. If veterinary medicine be allowed to play the part it should in the field of social security and health insurance, it will offer a great opportunity to returned service men to enter an undermanned profession, which cannot become overcrowded for years to come, and which will give the graduate a worthy field for public service.

The dearth of qualified veterinarians is due largely to misunderstanding of what constitutes the profession of veterinary medicine. While emphasis has passed from the horse to cattle, sheep, swine and poultry and to the fields of milk and meat hygiene, the amount of work as compared with the past has greatly increased. Failure to grasp this has resulted in the lack of interest shown by educationalists and the public.

The disbandment of the Canadian Army Veterinary Corps a short time after the outbreak of war is a glaring example of this lack of understanding. About the same time the U.S.A. re-organized their Veterinary Corps so that, when their country entered the war, officers were available who were highly trained in food inspection and sanitation. They are now in every theatre of war where American troops are operating.

When American troops went to Newfoundland, where Canadian troops had been located for some time, American Veterinary Corps officers found conditions highly unsatisfactory and had to make arrangements to have all milk and meat brought under inspection. American Veterinary Corps officers are also located at Edmonton, where they have a well-equipped laboratory for the examination of food and milk to ensure a high standard for army use.

In summary, it is respectfully submitted that any plan to establish Public Health Units is incomplete which fails to take into account and provide in its organization for dealing with animal diseases transmissible to man.

It is recommended that provision be made for the recognition of veterinary medicine by altering subsection 4 to read as follows:—"Unless otherwise prescribed the provisions of the last prescribed subsection shall apply only to members of the dental profession, the pharmaceutical professions and the profession of veterinary medicine."

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SESSION 1944
HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 6

THURSDAY, APRIL 20, 1944

WITNESSES:

Dr. J. J. Heagerty, Director, Public Health Services, Department of
Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance.

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1944



MINUTES OF PROCEEDINGS

THURSDAY, April 20, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Bruce, Cleaver, Coté, Donnelly, Gregory, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lockhart, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, McIvor, Mayhew, Slaght, Veniot and Wright.—22.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of Statistics;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. E. Howes, Research Staff, Bank of Canada;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics.

The Chairman read a letter from Mr. E. R. Powell, Secretary, The State Hospital and Medical League, Regina, Sask., requesting permission to give evidence before the Committee. It was agreed that they should submit a brief which will be printed in the evidence, and if the Committee desires to hear them personally they will be so advised.

The Chairman read a letter from Miss K. W. Ellis, General Secretary, Canadian Nurses Association, stating that Miss Maude Hall, Assistant Superintendent, Victorian Order of Nurses and Miss Blanche Anderson, Assistant Superintendent, Ottawa Civic Hospital, would attend the meetings of the Committee in place of the late Miss Alice Ahearn.

A brief from the Christian Scientists was ordered to be printed in the evidence. *See Appendix "A"*.

A brief from the Dominion Council of Canadian Chiropractors was ordered to be printed in the evidence. *See Appendix "B"*.

A statement respecting doctors' income was submitted by Dr. Heagerty in reply to a question by Mr. Johnston on March 30. This was ordered to be printed in the evidence. *See Appendix "C"*.

Hon. Mr. Mackenzie stated that the Provincial Departments of Health would meet in Ottawa on May 10, 11 and 12, and suggested that members of the Committee might show co-operation by attending that conference.

Mr. Johnston took exception to statements made by Mr. McCann at the previous meeting and asked that they be withdrawn. As Mr. McCann was not present at the time the matter was left in abeyance.

Dr. Heagerty and Mr. Bryce were called and examined.

Mr. Howden moved:—"That the provincial premium be placed at \$10 and that the limit of the income tax premium be raised to a degree as agreed upon by the actuarial advice, which will provide for the deficit in the amount."

After discussion the Chairman suggested that the various proposals respecting the financial aspects of Health Insurance made here to-day be submitted to the provincial ministers' conference without comment thereon. This was agreed to and Mr. Howden, with the consent of the Committee, withdrew his motion.

On motion of Mr. Donnelly the Committee adjourned at 12.45 p.m. to meet again at the call of the Chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

April 20, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: I have a request from the State Hospital and Medical League of Regina, Saskatchewan, to have representatives heard by the committee. I suggest in accordance with our regular practice they be asked to submit their brief, even if it is late, that it go on the record, and then if the members feel that they would like to hear them we can ask that they be present. Is that satisfactory?

Mr. JOHNSTON: I think in that regard your point is well taken. I think you said the other day there were other representations made to you?

The CHAIRMAN: I am coming to those.

Mr. JOHNSTON: I think the same thing should be done with those.

The CHAIRMAN: They are not quite in the same category because these others have actually submitted briefs.

Mr. JOHNSTON: Some have and some have not.

The CHAIRMAN: I will just complete this statement. It is your wish that they be asked to submit a brief and then we can call them later if you so desire? Is that satisfactory?

Some hon. MEMBERS: Yes.

The CHAIRMAN: I have a letter from the Canadian Nurses' Association informing the committee that Miss Maud Hall will attend meetings of the committee as the representative of the Canadian Nurses' Association. Last year you remember the late Miss Alice Ahearn attended nearly all meetings, and because of her death Miss Hall will take over those duties. There is another letter from the Canadian Nurses' Association which deals with certain sections of the bill which I shall read when those sections are under discussion.

Mr. JOHNSTON: What would be the purpose of her attending meetings?

The CHAIRMAN: Just to report back to the Canadian Nurses' Association on progress.

Mr. JOHNSTON: Not for questioning?

The CHAIRMAN: No, she really does not need to ask for permission to come, but it is for the purpose of record.

Hon. Mr. BRUCE: It is open to anyone to come.

The CHAIRMAN: There is a brief containing an additional submission from the Christian Science Association. I suggest, with the committee's approval, that this be placed on the record and after it has been read by the members of the committee we can discuss the material contained in it.

Mr. SLAGHT: A little louder, please.

The CHAIRMAN: I have a brief from the Christian Science Association giving additional information, or making additional requests, to their brief as presented last year. I suggest that it be placed on the record for later discussion after it has been read by members of the committee. Is that satisfactory?

Hon. Mr. BRUCE: Will it come up for discussion at the next meeting?

The CHAIRMAN: If you so desire, after it has been read. I also have a brief with additional material from the Dominion Council of Canadian Chiropractors. It is quite a long brief. I make the same suggestion as I made with reference to the Christian Science brief. Is that satisfactory?

Mr. MAYHEW: Will these briefs be available to the members?

The CHAIRMAN: They will be placed on the record and available in the *Hansard*.

Mr. CLEAVER: I wonder if it might not be wise when you are going to indicate a specific day for the committee to discuss a specific brief that you advise the association which has presented the brief that the matter is coming up for discussion on such and such a day so that they could have representatives present if they desire to.

The CHAIRMAN: No, Mr. Cleaver, we do not ask representatives to be present until we have discussed the brief; then if there is any material that needs clarification the committee can decide to call representatives.

Mr. CLEAVER: I take it our discussion is simply a preliminary discussion, and not for the purpose of arriving at any conclusion?

The CHAIRMAN: We may arrive at a conclusion, but before arriving at that conclusion we may ask representatives to answer certain questions.

Mr. DONNELLY: Did I understand you to say you will have these briefs printed in the report?

The CHAIRMAN: Yes.

Mr. SLAGHT: Mr. Chairman, following your suggestion I should like to further that idea. For instance, the Christian Science committee, whose brief you have referred to, have a representative here to-day, not with a view to addressing us orally unless requested to, but with a view to being ready to answer any questions that any member may want to put to them. Therefore, I think it would be well if you could indicate the date on which their matter will be heard. I understood you to say that the Christian Science matter, with regard to which I have some observations to make, will be heard at our next meeting?

The CHAIRMAN: Yes.

Mr. JOHNSTON: May I suggest further to what Mr. Slaght has said that as this report is going to be placed in the record—

The CHAIRMAN: Exactly.

Mr. JOHNSTON: I suppose it will be possible to have the record in our hands before the next meeting?

The CHAIRMAN: Yes.

Mr. JOHNSTON: Because if it is not those who have not got the brief will be at a great disadvantage.

The CHAIRMAN: Precisely.

Mr. JOHNSTON: It might be necessary to suggest to the printing bureau that they get a little bit busy.

The CHAIRMAN: In other words, the brief will not be discussed until it has been made available.

Mr. JOHNSTON: I understood you to say it would be discussed at the next meeting?

The CHAIRMAN: Assuming it will be in print.

Hon. Mr. BRUCE: Is it not a fact that the brief has been placed in the hands of all members of the committee?

Mr. SLAGHT: I understand that to be the fact.

Mr. DONNELLY: Not from the chiropractors.

The CHAIRMAN: It is not evidence until it is on the record.

Mr. DONNELLY: You have had a report from the Christian Scientists. I think we have all had one of those but I do not think any of us have had one from the chiropractors. What applies to one should apply to the other.

The CHAIRMAN: Yes, and before it can be discussed it must be on the record.

Mr. DONNELLY: Surely.

Mr. MAYHEW: Would it not be advisable to arrange the time when these different representations are going to be discussed?

The CHAIRMAN: We have already announced that the Christian Science brief will be discussed next time if meanwhile it has been printed.

Mr. CLEAVER: Then, Mr. Chairman, I want to make sure that I understand you correctly. Do I understand that a discussion will take place at our next meeting in regard to the Christian Science brief which will be simply a preliminary discussion for the committee to decide as to what additional information we want, and so on, before we arrive at a conclusion, or is it to be a discussion which will definitely arrive at a conclusion?

The CHAIRMAN: It may do either.

Mr. CLEAVER: In that event I do think that this group should be notified and should have an opportunity of having representatives here to answer questions before we reach a definite conclusion.

The CHAIRMAN: If for any reason any member of the committee desires further clarification of the brief a representative of the group will be asked to be present at a subsequent meeting. No conclusion will be arrived at if in the minds of any members of the committee there is any confusion with regard to the brief.

Mr. CLEAVER: I simply wanted to have that distinctly understood, and I thank you that it is now understood.

The CHAIRMAN: As you are aware a conference of the ministers and deputy ministers of the various provincial departments of health will convene here on the week of the 8th of May. Possibly the minister would like to say a word about that.

Hon. Mr. MACKENZIE: On the 10th, 11th and 12th of May the ministers of health and the deputy ministers of health from the provinces will be here mostly, I should think, to discuss the health features of the bill, the administration features of the bill. Of course, there are the financial features of it which must be referred to the main dominion-provincial conference. We would certainly welcome the co-operation of any members of this committee in their attendance if they can find it possible to be here during the discussions.

Mr. KINLEY: Will they meet with this committee?

Hon. Mr. MACKENZIE: That is a matter for the committee to determine. They are just meeting with the officials of the Department of Health as far as the present arrangements made?

Mr. DONNELLY: We will be notified when and where you meet?

Hon. Mr. MACKENZIE: Dr. Heagerty, would you say a word on that?

Dr. HEAGERTY: I think you have covered the whole subject, Mr. Minister. We have had a considerable amount of discussion on the subject of health insurance with the Dominion Council of Health, but that body comprises only the deputy ministers of health. We have had one joint meeting with the ministers and deputy ministers but no conclusion was arrived at at that time. The bill was not sufficiently advanced for us to give them a complete idea of what we had in mind. Now we feel we would like to have the ministers with us and present to them the bill and discuss it in detail. I have asked the

Hon. Mr. Mackenzie if he would have the kindness to outline the entire project. This he has agreed to do. It will be, no doubt, of very great advantage to have both the ministers and deputy ministers here to get their views. As you know, Ontario has passed a health bill and Saskatchewan has drawn up a health insurance bill. Mr. Mackenzie has thought it would be a good idea if the Hon. Dr. Vivian were to outline the Ontario bill, and the Hon. Mr. Uhrich the Saskatchewan bill. That would give us an opportunity to discuss the question from the standpoint of the provinces as well as of the dominion. That is pretty much what we have in mind.

Mr. LOCKHART: That raises a point in my mind as to whether we should come to any conclusion about any particular brief which has been presented here prior to hearing the provincial officers of health. I understood, following Mr. Cleaver's suggestion, that we may reach a conclusion.

The CHAIRMAN: Yes.

Mr. LOCKHART: In connection with a certain brief which has been presented.

Mr. CLEAVER: Only if the members are unanimous.

Mr. LOCKHART: You did not say that.

Mr. CLEAVER: I understood if any member wanted additional information he would get it.

Mr. LOCKHART: If the provincial presentations are going to have any bearing on the final conclusion of this committee with reference to any particular brief it would seem to me that the deliberations on any brief might be deferred until we know something about the two health insurance bills which are being introduced in the provinces. It seems to me as though we are putting the cart before the horse.

The CHAIRMAN: What we can do, Mr. Lockhart, quite properly is to report to the conference our opinions with regard to certain provinces.

Mr. LOCKHART: I am only saying, Mr. Chairman, that you made a reference that we would probably reach a conclusion next week or in a subsequent week.

The CHAIRMAN: On a specific brief; we may or we may not.

Mr. LOCKHART: If we hear the provincial officers of health on the insurance bills which have been prepared it might completely change our point of view on certain aspects of certain briefs which have been presented.

The CHAIRMAN: There will be no objection to such a change, I take it.

Hon. Mr. MACKENZIE: Speaking for myself alone, and not at all in any governmental sense, I feel very strongly that all these briefs being sent to us now are purely a matter for the provinces. I am strongly of that opinion. That may not be the opinion of the majority, but I think we cannot take away any rights or confer any. That is the way I feel personally about it. I think as to those groups which have got rights in the provinces the provinces have the right to say whether they shall retain the rights.

Mr. LOCKHART: They are only cluttering up the records of this committee. I agree with what the minister has said.

The CHAIRMAN: I do not think we are cluttering up the records at all. I think we have to dispose in some manner of every brief which comes to us.

Mr. JOHNSTON: I agree with the chairman.

Mr. HOWDEN: There seems to be a good deal of confusion and ambiguity with regard to the function of this committee. I take it this committee is for the purpose of studying proposals in the matter of health and to offer our suggestions and our views to the House of Commons as to what we think is a proper bill to go before the house. That does not mean we have any definite stand. The house is not bound to take our suggestions; it is not bound to take our advice. The ultimate outcome of the bill has to be arranged, as I understand it, within

the provinces, and if we can help them to arrange it by a little study and activity in the meantime so much the better. I do not see that we are getting in anybody's way or tramping on anybody's toes.

The CHAIRMAN: Dr. Heagerty has a statement to make.

Dr. HEAGERTY: The statement has been prepared in reply to a question that was raised by Mr. Johnston in regard to the incomes of doctors at the present time and the probable incomes under the health insurance plan. The brief is somewhat lengthy and it contains quite a number of tables. The tables themselves are somewhat complicated and I thought it perhaps might be better to have the brief mimeographed and placed in your hands for discussion at some future time.

Hon. Mr. BRUCE: I move that be done.

Mr. CLEAVER: Why not put it in the record?

The CHAIRMAN: And have it printed at once.

Mr. KINLEY: It is your brief, Dr. Heagerty, is it?

Dr. HEAGERTY: Yes, it is my brief.

The CHAIRMAN: At the last meeting we were discussing alternate plans for collecting contributions. We decided on the contributory principle. It seems to me this morning we should discuss the remaining subsections of section 2.

Mr. JOHNSTON: Before you go on with that, you were talking about correspondence a moment ago. I understand and, in fact, I have been informed that Dr. Arnott of London, Ontario, has presented a submission or sent a letter to the committee. Has that been given consideration?

The CHAIRMAN: No, it has not. I have no recollection of it.

Mr. JOHNSTON: Would you check that?

The CHAIRMAN: I will. There are one or two others that will come before the committee.

Mr. JOHNSTON: With your permission, before we go on with the debate this morning, there is a correction in the report I should like to draw your attention to on page 118 where Dr. McCann was speaking the other day about an ingrowing toe-nail. I see he has cut out the ingrowing toe-nail, not that it matters to me one way or the other, other than the fact that in the following paragraph I made reference to it. I think his toe-nail should be put back.

At the meeting the other day I was challenged here about some of the statements I had made and I was asked to bring the evidence to which I had referred. With your permission, Mr. Chairman, I will do that now. Before I do that I should like, so as to keep the record clear, to make reference to some of the remarks that were made in this particular regard. On page 122 of the reported evidence of the committee I should like to read a question which I asked of Dr. Heagerty so as to make the explanation clear. At the bottom of the page I asked Dr. Heagerty:—

May I ask Dr. Heagerty what percentage of the doctors in Canada belong to the Canadian Medical Association?

Then, on the next page Dr. Veniot had this to say:—

But the trouble at the present time is that our membership is reduced because a great many doctors are overseas. There are 3,800 doctors at the present time who are in the armed forces and who, because of that fact, are not active members of the Canadian Medical Association. That condition has prevailed since the war started. Confirming what Dr. Heagerty said, I may say that since the problem of health insurance has been under discussion a greater number of doctors have entered the Canadian Medical Association because they wanted to be informed through the channels of the Canadian Medical Association of what was taking place in the way of health insurance.

Then, down a little further Dr. Veniot has this to say:—

Their reason for registering this opposition was due to the fact that they had the misapprehension that health insurance meant state medicine, which is not the same thing at all.

At page 125, following the same thing up, Dr. Veniot has this to say:—

One of the reasons why a large number of doctors do not belong to the association is that they live in outposts. They can never manage to get to the meetings of the provincial organization. . . . Then a large proportion of the doctors are on the retired list. There are some 600 or 700 doctors who are over age to practice, and therefore are on the retirement list. So that, all things considered, I think that this committee should accept the idea that the Canadian Medical Association is the natural, logical body which should speak for the doctors of Canada.

Then I made this remark:—

Because in the first place, I have been shown a medical book in which it is stated—and I am not going to be dogmatic about the figure; this was about a year ago—

It was about a year ago I had seen the book.

Mr. SLAGHT: What page are you reading from?

Mr. JOHNSTON: Page 125.

—that 28 per cent of the total number of doctors in Canada belonged to the Canadian Medical Association.

On page 126 at the end of the first paragraph Dr. McCann had this to say:—

So when Mr. Johnston makes the statement that only 28 per cent of the doctors of this country belong to the association he makes a statement which is absolutely untrue, and I think, perhaps, he knows it.

Then I said:—

Mr. Chairman, Dr. McCann cannot say that.

I did ask the chair at that time, although it is not recorded, that Mr. McCann should withdraw that remark, but it was not withdrawn. Then, a few lines further down Dr. McCann had this to say:—

Mr. Johnston has made a statement which he would know is not in accordance with the fact had he taken the trouble to look up the facts.

Then I said:—

That is a statement which is made—

And I was interrupted by Dr. McCann, who said:—

By whom? Bring the statement here and put it on the record. I challenge you to bring the statement here.

Then, I said:—

Put the official figures on the record.

That was not done by Dr. McCann so I have accepted his challenge.

I did not want the committee to think for a moment I was stating something which I believed to be untrue, and I have gone to some considerable trouble to get the statement to which I was referring. I have it now. It was taken from the transactions of the 68th annual meeting of the Canadian Medical Association.

The CHAIRMAN: What is the date?

Mr. JOHNSTON: Ottawa, June 21, 22, 23, 24, 25, 1937. You will note this was just before the war started, and in the record which I quoted to you a moment ago Dr. Veniot had said that since the war started that membership had declined due to various reasons which he quoted and which I reread into the record this morning. This statement I am reading to you from was just before the war started.

The CHAIRMAN: Two years before.

Mr. JOHNSTON: Yes, but practically speaking it was just a little time before the war started. On page 34 of this report of the Canadian Medical Association they were speaking here about the cancer fund. It is rather amazing, too, that when this question was up for discussion in 1937 in regard to who would administer the cancer fund that the Canadian Medical Association was very much of the opinion that they would be the proper body to handle this fund which was being established. They took the same attitude then as, I take it, the majority of the members of the C.M.A. are taking at the present time in regard to this affair. I want to read what Dr. Meakins had to say in regard to that which would be applicable in the same case here. On page 34 of the transactions of the Canadian Medical Association, Dr. Meakins had this to say and, of course, Dr. Meakins is a member of the C.M.A.:—

I fear very much that, if the trustees hand over to the C.M.A. \$40,000 a year, the people will criticize that action. If, on the other hand, the trustees, with this money in hand, set up machinery for the establishment of a national cancer association and, although spending all their interest and part of their capital, would also continue to try to raise additional money, it might be delegated to us to take charge of the propaganda as far as it concerns the medical profession. Are we a body that would command the respect of the whole laity in Canada to carry out this particular scheme? I rather think we would be taking on a big responsibility which might be done better in some of its aspects by a national organization in which the laity is represented as well as the medical profession.

Then Dr. Primrose speaks:—

The trustees cannot do anything but disburse money. They could not establish an organization.

I am coming now to the section in which Dr. Meakins refers to the number of Canadian doctors that belong to the C.M.A. Dr. Meakins speaks:—

The Canadian Medical Association only represents 28 per cent of the medical profession in Canada.

That is definitely the figure I quoted the other day, and I was speaking from memory. Now you have verification there from the official records of the Canadian Medical Association meeting which was held here in Ottawa on June 21, 22, 23, 24 and 25 of 1937. Therefore, I think, with all due respect, that Dr. McCann should apologize for the ungentlemanly remarks which he made the other day.

Mr. KINLEY: Was that disputed in any further discussion?

Mr. JOHNSTON: No, I have read it very carefully and I can find no place where it has been disputed. In fact, there was no argument about it at all.

Mr. DONNELLY: That was only his opinion. Dr. Routley gave evidence here, and surely his evidence should carry more weight than that.

Mr. JOHNSTON: Dr. Routley was in this, too.

Mr. DONNELLY: Dr. Routley gave evidence here before this committee which was absolutely different.

Mr. JOHNSTON: He gave evidence at this meeting, and I was particularly concerned when I saw that. What Dr. Routley said when he was before this committee I am not disputing, but I am placing on the record the verification of what I said the other day and which remark Dr. McCann said was untrue. I think yet, Mr. Chairman, with all due respect, that Dr. McCann should withdraw those remarks.

The CHAIRMAN: We shall have to wait until Dr. McCann is present.

Mr. JOHNSTON: I am sorry he is not here.

The CHAIRMAN: I should just like to point out you were quoting a statement in June, 1937, and Dr. Routley was speaking of the summer of 1943.

Hon. Mr. BRUCE: I was just going to point that out, that what Mr. Johnston says may have been the situation, and no doubt was—I take it his reading is correct—in June, 1937, but what we were discussing the other day was what the situation was in 1943, five years later.

The CHAIRMAN: Six years.

Hon. Mr. BRUCE: If I recollect correctly, somebody asked Mr. Johnston if he would state his authority and the date of that authority. Unfortunately, he was not able to do it then. I am quite sure that Dr. McCann would be willing to retract what he said the other day, if he were here—I am sure that I would be—and say that the misunderstanding arose because Mr. Johnston did not give us the date of his figure, which was of material importance. In six years there has been a great increase in the membership of the Canadian Medical Association, and the figures given by Dr. Routley on April 6, 1943 which I repeated here at the last meeting would show that.

Mr. DONNELLY: Mr. Chairman, I have in my hand the report of the Special Committee on Social Security, this committee, under date of April 6, 1943. Dr. Routley was giving evidence before the committee last year, and on page 134 this is what we find:—

Membership in the Canadian Medical Association is voluntary, every Canadian doctor in good standing in his community being eligible for membership. There are registered in Canada approximately 10,600 doctors, 8,500 of whom are English speaking and approximately 2,100 French speaking. Of this total number the Canadian Medical Association has 6,388 members, of whom 300 are French speaking.

This is the evidence given by the secretary of the association who has the records, and as given to this very committee on April 6, 1943.

Mr. WRIGHT: It is quite evident from the statement made by the honourable gentleman that the doctors, as soon as it became evident that a health bill was likely to be placed before the Dominion of Canada immediately got into their own association to protect their rights. That is the conclusion I would draw from the remarks made here.

Hon. Mr. MACKENZIE: It is good union practice.

Mr. KINLEY: It seems to me that the record from which Mr. Johnston read justifies his statement, but it does not prove it is true. It may be that we should find out from official sources the membership of the Canadian Medical Association.

The CHAIRMAN: We were given that last April.

Mr. VENIOT: May I just say a word. I do not want to start a controversy over this Canadian Medical Association membership, but may I say that the Canadian Medical Association was reorganized in 1921. I was present in Halifax when that reorganization was made, and at that time I venture to say that we were no more than perhaps a fifth or a sixth of the entire number of medical practitioners in Canada. Following that reorganization of the

Canadian Medical Association, our membership started to grow and it has been growing ever since. The figures quoted by Mr. Donnelly and given in 1943 are correct; the figures which we had a couple of weeks ago at the meeting of the Canadian Medical Association executives showed that we had a membership of 6,600. In the address which I made at our last meeting I was talking probably a little *ex abrupto*, you might say—without notes, without proper figures and without proper facts right under my fingers. But I think it is correct to say that the membership of the Canadian Medical Association has grown since our reorganization and since we have been meeting with the provincial bodies continually each year. Having joint meetings of the executive of the Canadian Medical Association with the provincial divisions has been one of the great reasons contributing to the increase of our membership. No doubt also, as my friend Mr. Wright has pointed out, it is quite natural for the doctors to want to get into the Canadian Medical Association in greater numbers now that we see steps are being taken to change the entire outlook of medical practice in Canada; and who can blame them for doing that?

Mr. JOHNSTON: I would not blame them at all. That is not my point.

Mr. VENIOT: No. I want to make this point. Who could blame them for doing that? We have the right to increase our members and group together just the same as any other body has, and to form a union. The mechanics form a union and the tramway men form a union. It is also our privilege to do so. I merely wish to point out that if we are increasing in numbers, it is due to several factors, some of which I was not in a position to enumerate last time.

Mr. JOHNSTON: I am not questioning anything you said last day, Mr. Veniot.

Mr. VENIOT: No. I do not want to enter into a controversy with you or anybody else concerning that particular point.

Mr. JOHNSTON: No.

Mr. VENIOT: But on the other hand I do not want anybody to say that the Canadian Medical Association has no authority to speak for the medical profession of Canada. We definitely have, and as time goes on our authority to speak for the medical profession of Canada grows and it will keep on growing.

Mr. SLAGHT: Could the doctor tell us whether in the union there is any provision for strikes?

Mr. HOWDEN: With all due respect, I do say that I do not believe this discussion is worthy of the time it is taking up. However, as an old doctor—and I am getting pretty well on in years—I should like to state what is actually the pith of the subject. Actually, all the doctors in Canada are in sympathy with the activities and endeavours of the Canadian Medical Association. In the province of Manitoba we have the Winnipeg Medical Association, we have the Manitoba Medical Association and we have the Canadian Medical Association. But the doctors are interested only in the activities of the association, as a rule, which they are able to attend. There is only one joint meeting of the Canadian Medical Association every year. It is true, as Dr. Veniot says, that they send representatives to the provincial meetings, and since they have invoked the policy of sending representatives to the provincial meetings, the membership of the bigger organization has grown.

We are all in sympathy with the endeavours and the purposes of the Canadian Medical Association. I will bet you that the number of the medical men in Canada who are not heartily in sympathy with it does not amount to 2 per cent, but we do not always bother to register our memberships. Let us say that this year there is a meeting of the Canadian Medical Association in

Manitoba. The probabilities are that the Manitoba doctors, as far as they can, will flock into the meeting and they will all re-establish their memberships. Next year the meeting will be in British Columbia, say; many of the doctors in Manitoba will not send in their yearly donation and they are stricken off the list, so that the membership changes from year to year. As I say, individuals are interested only in the undertakings with which they are actually connected. There is no question about it, we are all behind the Canadian Medical Association. We know that they are endeavouring to further the best interests not only of the medical profession in this country but of the people themselves, and we are heartily behind them.

Mr. McIVOR: Mr. Chairman, I should like to say a word for the medical association of Thunder Bay. They are capable men, and I think nearly every doctor at the head of the lakes is organized. They are very generous, because they invited a man like me to address them, and I did. I found that the opinions of the medical association at the head of the lakes stood out as unselfish and thorough. I doubt if there are any doctors at the head of the lakes who do not belong to it. However, I think that Dr. McCann and Mr. Johnston have rivetted this thing on our minds. I am sure that I will not forget that 28 per cent mentioned by Mr. Johnston, and I will not forget the statement made by the others. I think they have served the committee well. But these men are members of the House of Commons, they are sensible men and they can settle their differences either in the committee or outside.

The CHAIRMAN: I am sure, gentlemen, that every member of this committee wishes to carry on the business of the committee with the greatest courtesy and harmony. We are dealing with an important measure of human welfare which should not tolerate any acrimonious debate. Mr. Johnston complained, as I understand, that Dr. McCann stated that Mr. Johnston made an inaccurate statement, knowing it to be inaccurate.

Mr. JOHNSTON: That is correct.

The CHAIRMAN: And he asks Dr. McCann to withdraw that imputation. Certain things are said in the heat of discussion which are not intended, I am sure, to be offensive, but which sometimes are. I think if Dr. McCann would just withdraw that statement, it would end the whole thing.

Mr. McCANN: Mr. Chairman, I have just been informed of the discussion here this morning. I do not, as a rule, do anything very precipitously.

The CHAIRMAN: No.

Mr. McCANN: I have no intention of withdrawing anything until I have read what Mr. Johnston's statement is this morning. I made no statement with reference to him at the last meeting which I did not think was accurate; and, as I say, the position remains exactly the same as it was, until I have had an opportunity to see what the debate was this morning.

The CHAIRMAN: Is that satisfactory, Mr. Johnston?

Mr. JOHNSTON: It will have to be.

The CHAIRMAN: We can return to it later.

I would suggest then that this morning we discuss the second page of this memorandum or agenda we had last time with reference to the amount of contributions. I would also suggest that we should have an expression of opinion with regard to the contributions, and not only the majority opinion but any other alternatives, so as to place before the provincial conference of ministers of health, one, two or three plans, and they can form their opinion and judgment with regard to the best plan and the most satisfactory one. Is that agreeable? If so, under section 2, subsection (b)—

Mr. HOWDEN: Is that of the draft bill?

The CHAIRMAN: No, of the agenda that was put before us last time. You have this. I will read the three plans suggested. Number 1 is on the front page, "amounts to be collected by the annual contribution of \$12 and by income tax." Then there are three alternatives on the second page. What is your will? Do you wish to take those up in order?

Mr. JOHNSTON: I suggest that they be taken up in order; in that way there will be no confusion.

The CHAIRMAN: Then (a), the second alternative will be taken next.

Mr. JOHNSTON: Yes.

The CHAIRMAN: It is: "Increasing the amount of contribution of \$12 and abolishing the contribution by means of income tax." Dr. Howden, I think you suggested that \$12 was too high.

Mr. HOWDEN: Mr. Chairman, I do not believe it makes a particle of difference whether we adopt \$10 or \$12. I think what we should do is to adopt one of those two figures and get on with the business of the committee.

Mr. JOHNSTON: Mr. Chairman, I can only say what I said before. When Dr. Howden suggested the other day that the contribution be lowered from \$12 to \$10, I stated that I was in agreement with him. If we are going to have a contribution, then I would definitely say that the \$10 should be chosen in preference to the \$12. Dr. Heagerty, I think, suggested that we take the \$12 and do away with any other tax on incomes. I believe I have stated that correctly. If I have not, Dr. Heagerty will put me right. I am not going to argue over the \$10 or \$12. My preference is \$10, of course, because it is the lesser of two evils.

Mr. HOWDEN: It is a more attractive figure.

Mr. JOHNSTON: Yes, that is right. I believe that no other charge should be made, and that if there are any other moneys required they be taken out of the general revenue to meet this expense. I think that was the position I took before, and I should like to state it again.

Mr. McCANN: Mr. Chairman, I cannot agree that it is a more attractive figure, because the contribution will likely be made monthly; and if it was \$1 per month it would be just as easily collected as 87 cents or whatever the other work out at, and probably would mean an awful lot less work. There is also the point that \$2 a year more as a contribution from each individual means a great deal to the state. If the service is worth anything on a contributory basis, I submit that it is worth \$12 a year or \$1 per month.

Mr. WRIGHT: With regard to what Dr. McCann has just said about the money being collected, I do not think that would be the fact. It is not going to be a deduction from income. It is going to be paid in the form of a registration fee, and certainly each individual is not going to go monthly to register and pay a dollar fee. I think the registration fee of \$12 will be paid certainly in not more than two payments in the year.

I want to again express my opinion that this \$12 is too much, that there are parts of Canada and certain groups within our economy on whom this amount will be a real hardship, although perhaps not right to-day when everybody is enjoying an income which is higher than we have enjoyed since probably the last war. In the province of Saskatchewan for five years we had an average farm income of something under \$300, and that \$12 contribution is certainly too large an individual contribution on that basis. It is paying too large a percentage of your total income for medical services. That also applies in the province of New Brunswick, the province of Quebec, in northern Ontario and, I think, in all of our newer settled areas. I certainly am not in favour of suggestion (a) which would increase that amount and abolish the contribution by means of income tax. Later on I shall have more to say with respect to (b) and an alternative to suggest.

The CHAIRMAN: Have you any definite specific suggestion with regard to (a)?

Mr. WRIGHT: The only thing I would suggest is that we do not adopt it. I do not think we should increase the individual contribution as suggested under (a). When it comes to (b), I think there is a great deal of merit in the suggestion there. As a matter of fact, I would go even further than is suggested in (b). I would make, as I suggested at the last meeting, an amendment suggested by, I think it was, one of the honourable members from Quebec.

The CHAIRMAN: Mr. Cote.

Mr. WRIGHT: Yes, Mr. Cote. I suggested at that time that 50 per cent of the total cost of the scheme be taken from the consolidated revenue of the dominion, that 25 per cent be taken from the consolidated revenue of the provinces—that 25 per cent to include the administrative costs—and 25 per cent be taken as a registration fee from the individual, which would amount approximately to an \$8 contribution instead of \$12 from the individual. As you will remember, at that meeting or the one previous, I pointed out that there were certain provinces in this dominion which might find themselves in circumstances under which they would not be able to meet their share of this bill. I suggested that we should have a clause in the bill which would provide for something the same as was provided in the Rowell-Sirois report, whereby the province, where it could prove that its income was below the average for the dominion, would receive a special grant from the dominion for purposes such as this. Those are my suggestions with regard to that.

The CHAIRMAN: Thank you, Mr. Wright.

Mr. LOCKHART: Mr. Chairman, there is a point which seems to arise in connection with the discussion of subsection (a). I presume it would be a little out of order or it may be out of order to ask Dr. Heagerty a question.

The CHAIRMAN: Oh, no.

Mr. LOCKHART: I am wondering if he has had even informal deliberations with the health officers, ministers or deputy ministers of the provinces. It would seem that their attitude and suggestions might be very appropriate, having regard to the policy adopted by this committee. I am just wondering if Dr. Heagerty would care to venture anything as to the attitude of the heads of the health departments in the provinces; because after all, I think it is going to come back very largely to administration by them, and I think their advice and direction should be accepted. I was wondering whether Dr. Heagerty was prepared to tell us anything along that line.

Dr. HEAGERTY: We have not had any discussion whatsoever with the provinces in regard to the estimates of costs. In fact, we have not gone into the details of the bill for the reason that I mentioned previously.

I should like, however, if I may be permitted to do so, to extend the discussion and to point out that the \$12 contribution is probably the lowest contribution that is imposed by any country in the world, having in mind the benefits that are provided. There is not anything that we know of in the way of preventive services and treatment benefits that is not provided in this bill. This is practically giving away health insurance to the people. There is no doubt that it is most equitable in so far as the \$12 is concerned.

The CHAIRMAN: Is there any further discussion on subsection (a)?

Mr. HOWDEN: Mr. Chairman, I do not know that I have much more to add to what I indicated the other day; that is still my position. I suggested that the premium be dropped from \$12 to \$10 as I thought that \$10 was a more nominal figure and would appeal more to those people in the lower income brackets. I felt that by boosting the income tax premium, it would have no effect on those people in the central brackets, that they would pay about the

same amount in the end, whereas the poorer people would pay less and those who were better able to pay would take up the difference by elevating the limit in the income tax premium. I do not see that it makes a great deal of difference, because this federal government undertakes to come to the relief of those individuals who cannot pay the income tax contribution. I do not believe there will be any great complaint anywhere in the country with regard to this \$12 or this \$10 premium. I think that this committee ought to adopt this and get on with some other part of the bill, in one way or another. If you want it in the form of a motion, I shall be glad to move now to the same effect as my suggestion, that the provincial premium be placed at \$10 and that the limit of the income tax premium be raised to a degree as agreed upon by the actuarial advice which will provide for the deficit in the amount.

Mr. JOHNSTON: May I ask a question of you there, Dr. Howden?

Mr. HOWDEN: Yes.

Mr. JOHNSTON: You will notice in (b) there, "retaining the amount of contribution of \$12, abolishing collection by means of income tax and supplementary payment through the national revenue in lieu thereof." I was wondering if you really meant to take the additional amount above the \$12 out of the national revenue rather than increasing the income tax, because there is quite a difference there.

Mr. HOWDEN: No. I intended to make one side of the premiums balance the other. My idea was to boost the income tax contribution.

Mr. JOHNSTON: Do you not think it would be much fairer to take it out of the general revenue as suggested in (b), although we are discussing (a). But the alternative given there in (b) is where you take it out of the national revenue rather than bother with the income tax at all.

Mr. HOWDEN: My idea was to lighten, to some degree, the load on the lower income brackets and to boost it a little bit on the higher.

Mr. JOHNSTON: But are you doing that?

Mr. HOWDEN: I doubt if it will be done unless we do it in this way.

Hon. Mr. BRUCE: I think Dr. Howden's motion is only confusing the issue a little, with all due respect. We have been talking about the difference between \$10 and \$12 in the contribution. Let us dispose of that first.

Mr. HOWDEN: You have to make up the deficiency in some way.

Hon. Mr. BRUCE: Never mind that for the moment. I am going to suggest that we get away from that issue, because you will see Dr. Howden has raised another one which Mr. Johnston has referred to, that he would add the difference to the income tax, whereas in (b) which is the plan I think that Mr. Cote moved on the last occasion we met, and I seconded—although I did not need to second it—it states definitely that we would abolish collecting by means of the income tax and that supplementary payments would be paid by the national revenue in lieu thereof. So that if there is any difference of opinion with regard to whether it should be \$10 or \$12, if we settle that, then we can get on with plan (b).

Mr. McIVOR: To get on with the business, I will second Dr. Howden's motion. I remember a committee of railroad men from the union called on me and they said the whole thing would cost more than they can get their health insurance for. I answered that as best I could, and I upheld the committee in the plan of contributory insurance; but these men told me and they proved it to me, that from their own point of view they can get better insurance by banding themselves together than they can in this. I second the motion.

Mr. DONNELLY: Mr. Chairman, we are endeavouring to put through a measure of legislation for health insurance, and it is proposed that in regard to this bill we put through we are to have the co-operation and assistance of the provincial governments. We are coming to a very, very important part, that is

the financing of this bill or how it is to be financed, and where we are to get the money. We must remember that this \$12 is to be collected by the provincial governments. They are the ones that are to go out and collect it, and it is up to them pretty well to say whether it is too much or too little. I do think that we are a little premature to start in and say we are going to ask them to give us \$10 or ask them to give us \$12. I think we should wait until we see these people and hear what they have got to say about whether they think it is too much or too little. That is the crux of the whole thing. It is all very well to decide you are going to do something but you have got to decide the most important thing, and that is the money end of it, the raising of the money. If the provincial governments do not want to co-operate with us they have not got to do so. We put through legislation, and if some provinces do not want to have it put into effect in their province they do not need to do it. It is just the same as the old age pension law. We put it through and made it operative as far as we were concerned as a dominion, but it was not in operation in all the provinces for a long time afterwards. We want to be sure when we are doing this we are going to do something which is going to meet with pretty nearly universal approval in every province in the dominion. I think we would be well advised before we decide on anything of this kind to wait until the provincial representatives are here and hear what they have to say with regard to this amount.

Mr. HOWDEN: We are not putting through a bill; we are merely offering advice on the administration. They want to get the slant of the House of Commons on this bill.

The CHAIRMAN: Just a moment; may I make this clear? When the conference of provincial health ministers meet here on the 10th of May they will expect us to give them certain recommendations or suggestions. It may be one plan, two plans, three plans or four plans in the order of precedence. Surely the committee is expected to do that and are obliged to do it. That is all we are trying to do.

Mr. McGARRY: I would agree with what the chairman has to say. When these representatives from the provinces come here they will expect that we will have some plan to submit to them.

The CHAIRMAN: Recommendations.

Mr. McGARRY: After all, we are gathering information, and when these people come here they want to know what our plan is before they will adopt it. I think it is our function to have that plan prepared.

Hon. Mr. MACKENZIE: Mr. Chairman, I rather think the conference on the 10th of May will not deal conclusively with the financial aspects of these proposals. I think that will be part of the larger scope of the real dominion provincial conference. The intention of this preliminary conference was to deal with the question of health features of the bill and the administration features, the question of fees and administration in the provinces. I am strongly of the same opinion as the chairman. I think it would be a mistake to be dogmatic or mandatory on any one single specific plan. I think we can put in the order of our opinion one, two or three alternatives for discussion with the provincial authorities and that that would be helpful, but personally I would be somewhat embarrassed if we came to one single specific plan because I might be committing the government to a specific scheme, and I do not feel free so to do. I do appreciate the opinion of the committee as a guide in the future. I see no objection to putting two or three alternatives in the order of your preference. I think that would be a very strong guide either to the government or to the provinces in the future.

Mr. HOWDEN: In other words, you want to offer these people something to shoot at when they come here.

Hon. Mr. MACKENZIE: Exactly; I see no objection to the committee indicating your own preference say to the \$12, \$12 plus some scale of income tax, or the recommendation of the finance committee.

Mr. McCANN: Do you not think it is much more important that this committee should adopt certain principles rather than the details?

Hon. Mr. MACKENZIE: Yes.

Mr. McCANN: I think that is a fundamental thing. The committee should study the underlying principles and be in a position to recommend or to state what is the position of the committee with reference to the principles.

Mr. WRIGHT: In the matter of procedure did Mr. Cote not make a motion?

The CHAIRMAN: I am just coming to that.

Mr. WRIGHT: Would that not come before Mr. Howden's motion?

The CHAIRMAN: If you will look at subsection (c) it is: "If no conclusion regarding above, it is desired that an alternate plan be suggested?" Mr. Cote's plan is an alternate plan.

Mr. JOHNSTON: Was not his (b)?

The CHAIRMAN: No. Mr. Cote's amendment is here, that a flat contribution rate of \$12 per adult per annum be suggested to the provinces, leaving the provinces to modify this basic rate without changing the total amount for which the provinces would be responsible on the per capita basis.

Mr. COTE: Perhaps it would be easier to divide that motion in two. First I would suggest that the flat contribution rate to be suggested to the provinces be on the basis of \$12 per adult per year and in a second motion I would suggest that the necessary power be given to the provinces to adjust or modify the rate of \$12 to meet their own particular problems or needs.

Mr. HOWDEN: I think that is in the bill somewhere now.

Mr. HEAGERTY: Section 4 of the bill.

Mr. COTE: I have drawn the attention of the committee to section 6 of the provincial statute which we suggest. From that section it appears that the provinces will have no power to reduce the flat rate contribution unless it has been applied for by the individual concerned. My plan would be to give to the provinces the power to take the initiative of reducing if the provinces feel that a different scale should be adopted for the fixing of this flat rate contribution. That is without reducing in the final outcome the provincial contribution into their respective health insurance funds which was always to be calculated on the basis of \$12 per adult per year. Perhaps it would be more expeditious to study the first part of the motion at this time.

The CHAIRMAN: Dr. Howden has made a motion to that effect that the contribution be \$12.

Mr. HOWDEN: \$10.

Mr. COTE: My suggestion is to retain the \$12 flat rate contribution.

Mr. SLAGHT: As an amendment.

Mr. COTE: I made a motion at the last meeting that the flat contribution rate to be suggested to the provinces be on the basis of \$12 per adult per year.

Mr. SLAGHT: I will second that.

The CHAIRMAN: Mr. Bryce, would you care to comment?

Mr. BRYCE: In the report which this committee on finance made we did take into account the possibility of the provinces levying less than a \$12 flat rate contribution. On page 3 of the evidence of this committee, the meeting on March 1, the minister said:—

The committee therefore recommended—and in speaking of the \$12 fee if I may quote him—provided that where any province, after two or

more years' operation of health insurance, can demonstrate its ability to provide health services of the required standard at a cost per insured person less than the dominion average, such province may reduce the flat annual contribution proportionately, but the \$12 amount shall be used for the purpose of calculating the dominion grant.

Mr. JOHNSTON: Whereabouts is that?

Mr. BRYCE: Just below the middle of the page.

Mr. JOHNSTON: Subsection 1?

Mr. BRYCE: Paragraph 1, subsection (a). What we had in mind was that in those provinces where the cost might reasonably be expected to be lower they might charge a lower contribution. I think, if I may recall what it was we had in mind, we did not want the contribution set so low that the shortage of funds might lead a province into establishing services of a standard that was not really adequate, but that where services could be provided at a cost which justified a lower contribution a lower contribution would then be accepted.

Mr. JOHNSTON: May I ask a question? How would that be possible in view of the fact the provinces would be required to give the dominion \$12 anyway? As I interpret what you said while the provinces would be responsible for the \$12 they may lower that \$12 to the individual and make up the difference from their general revenue. Ultimately they would give \$12, anyway, so the services would not be lowered.

Mr. BRYCE: It is the province which manages the fund.

Mr. HOWDEN: It is the dominion which gives to the provinces, not the provinces giving to the dominion.

Mr. BRYCE: The dominion will be making certain payments to the provinces.

Mr. JOHNSTON: But the provinces would have to make up a total amount of \$12.

Mr. BRYCE: If the costs were \$12, but if the costs were lower our suggestion was they would be able to have a lower contribution. In the draft of the provincial bill we could not spell all that out. We have a figure of \$12 there, but in the report of our subcommittee on finance we did make this suggestion which would provide for the idea which some of the members have had in mind.

Mr. JOHNSTON: Would it be possible for a different standard of health to be established in each of the provinces? I would not think that would be desirable.

Mr. BRYCE: It would be a question of whether the cost could not be lower in some provinces than in others.

Mr. MCGARRY: With the same standard.

Mr. BRYCE: With the same standard.

Mr. JOHNSTON: As long as you maintain the same standard of health service.

Mr. BRYCE: That is what we had in mind. We said: "Provided that where any province, after two or more years' operation of health insurance, can demonstrate its ability to provide health services of the required standard at a cost per insured person less than the dominion average."

Mr. SLAGHT: May I ask how that last sentence works out, "but the \$12 amount shall be used for the purpose of calculating the dominion grant." Suppose a province fixes the fee at \$6 instead of \$12; then does the dominion have to pay that province on the footing that they have collected \$12, just as though they have? What does that mean, that the \$12 amount shall be used for the purpose of calculating the dominion grant? Take a province which fixes it at \$6 and not at \$12; what happens?

Mr. BRYCE: The way the matter works, the dominion grant is calculated with reference not to the cost of operation in a particular province but rather to the average costs of operation in all the provinces. It is that average cost of operation in all provinces which is compared with the \$12 figure to get the amount of the grant to the province. Therefore, we propose that if the costs in a particular province should be lower than the average they can charge lower than the average contribution, but in determining the amount of the dominion grant to the province you should use the average cost in all the provinces. The \$12 is the standard fee for all the provinces, but a province would not suffer unduly thereby because their cost will be less than the average and their contribution will be less than the average.

Mr. HOWDEN: Does it not mean that the dominion government will pay the difference between the \$12 and \$21.60?

Mr. BRYCE: Yes, unless the average costs turn out to be something different than \$21.60.

Mr. WRIGHT: Suppose the average cost in a province was up over \$21.60; suppose it was \$25 in British Columbia. Who would meet the difference between the \$21.60 and the \$25? As I understand it from the bill it would be met 50 per cent by the province and 50 per cent by the dominion?

Hon. Mr. MACKENZIE: That is right.

Mr. WRIGHT: That is one thing I want to know as to whether that is correct. Then I want to know whether, in the case of a province being able to operate at say \$18—that is less than \$21.60—the dominion makes a saving of half of that or is the saving entirely credited to the province?

Mr. BRYCE: I have not looked at it recently but my understanding is if the cost in a particular province is above or below the average that does not affect the amount of the dominion grant which it receives. Therefore any increase in cost above the average for all the provinces, or any saving in cost below the average for all the provinces, is a cost to, or a saving for, the province. That is to say, the province is offered an incentive there to keep the costs under control, which we thought was proper because they are administering the scheme. If, however, the average costs for all provinces turn out to be substantially different from \$21.60 then we propose that the dominion contribution should be such as would result in the dominion bearing half the excess above \$21.60, and the provinces through flat contributions, or otherwise, as they see fit, bearing half the cost.

Mr. SLAGHT: Does that not make for discrimination? I may be stupid about this, but take a province which taxes its people \$6 only alongside a province which taxes its people \$12. They both go to the dominion treasury for their grant. You are going to give the province which only collects \$6 from their people the same ratio of grant out of the dominion treasury that you give to the province which collects \$12.

Mr. BRYCE: I have not made it sufficiently clear.

Mr. SLAGHT: If that is not so I am not troubled further.

Mr. BRYCE: I think I can perhaps make it clearer if I put it this way. The dominion grant to the provinces will be the excess of the average cost per individual over \$12 for each individual in the province. It will be the same per capita for all provinces, and therefore it will not depend on the costs in the individual province but will be fair as between all the provinces receiving it. That is, they will each receive the same amount per capita. I think that puts it more clearly.

Mr. HATFIELD: Mr. Chairman, my opinion is that 50 per cent of this fund should come out of the federal revenue grant to the provinces and 50 per cent from the provincial revenues with the suggestion to the provincial governments

that they should collect not less than 25 per cent of their costs from the individual. I am opposed to any of this fund coming out of income, especially in the low brackets. Things are complicated enough now without taking anything from income, unless you take it from the higher brackets. The way the Act reads now you take it all from the low bracket income tax payer.

I am also opposed to having the provincial government pass any of this tax on to the municipalities. The municipalities have an obsolete way of collecting taxes. They dig right in a person's pocket and take it out. Provincial governments have more modern ways of collecting taxes. In our province we have the tobacco tax, the revenue from liquor and revenue from a great many things that should pay towards this health tax.

Mr. HOWDEN: Question, Mr. Chairman.

Mr. MAYHEW: Before the question is put, I think we are going to do the bill a great deal of harm if we fix on a definite sum of money to-day. If we propose it as a suggestion of plans 1, 2, 3 and 4, as many as you like, that is all right, but if we let it be known through the press and other means we have suggested in this committee an amount of \$12 or \$10, then that is going to be the amount that is in the minds of the people. We may have to change it, but the public is going to still hold that opinion and we will have to disabuse their minds of it. I think we should be very careful in passing any resolution to-day dealing definitely with the amount of money involved in paying for these services.

As a matter of fact, I think we are studying the bill from the wrong end. I think we should find out what is in the bill itself and then see what we are going to pay for it, but leave the financial aspect of the bill to the last. I should like to know what we are going to get for the money before we actually prescribe it.

The CHAIRMAN: When that conference meets the main question, as I see it, on the part of the provinces will be what does it involve? What is the contribution; what is the opinion of the committee with regard to the cost to the individuals of the provinces? My suggestion was that we should give a lead and express our opinion in the form of 1, 2, 3 and 4.

Mr. MAYHEW: I quite agree with that, but a motion is being made here that it be \$10 or \$12.

The CHAIRMAN: It is only to sound out the opinion of the committee.

Mr. HATFIELD: We have been studying this bill for two sessions. Surely the ministers of health in the different provinces who are coming here will want some opinion from us and that is how we suggest it.

Mr. JOHNSTON: May I ask Dr. Heagerty if his opinion is the same now as it was a few meetings back when he suggested that \$12 be the fee and that the rest be taken out of the general revenues?

Dr. HEAGERTY: Yes, but that is just a personal opinion. My reason for that opinion is that I think the maximum contributions for single persons, \$42, and for married persons, \$74—those are in the income classes of \$1,600 and \$2,200—are too high. I think they are far too high. I am looking at this from a purely personal standpoint for the reason that I am going to be superannuated in a very few months from now, and I shall have to pay \$74 for myself and my wife and \$12 for my boy. That is more than I shall be able to pay. It will be a case of going to jail if I do not pay or paying a fine. I consider these amounts are inequitable. The people of Canada just simply cannot pay them. It was pointed out here that the maximum income of wage earners is very low. It is higher to-day than it was in 1941 when the amount of \$960 was indicated as representing the income of two-thirds of the people in the country, but nevertheless I do not think for the majority it will reach the point of \$1,600 for single persons and \$2,200 for married persons after the war. That is, less the ordinary

income taxes they will have to pay. The majority of the people I have talked to have told me quite plainly that the whole thing is inequitable because of the amounts of the contributions. They are not concerned so much with regard to the collection by the province or the dominion, but the contributions in their opinion, are quite an erroneous conception of the depth of the average purse.

The finance committee, of course, are considering this from the standpoint of the ability to collect money both from the dominion and from the provinces but I fear they may have lost sight of the ability of the people to pay.

Mr. JOHNSTON: Hear, hear.

Dr. HEAGERTY: I think that is a very important consideration. There are other considerations that enter into this question, but I do not want to discuss them at the present time, but the proposed contributions are condemned by people I have talked to who are, I would say, in fairly good circumstances, certainly in as good circumstances as I am myself. I just conclude with this note, and that is that one of the more important—perhaps the most important—object of health insurance is to make available to all of the people all of the medical benefits that can be provided at a certain specified time whether or not they have the money—and in addition to reduce the cost to the average individual. This is not reducing the cost to the average individual. It is increasing the cost. Very few of us to-day pay anything like \$50, \$60 or \$70 for sickness a year and we should certainly not be asked to pay those amounts. The average cost of illness to the single individual is \$24 a year and, as has been pointed out by the finance committee, the average cost to a family is \$36. If that is the cost we certainly should not pay more than that amount under this plan. We should not pay more than we are paying to-day. Another point is this; by these payments we are relieving municipalities of a certain amount of the burden of payment for medical care and hospital care and are deliberately placing that burden upon the public. So that we have got to give very careful consideration to the contributions that are imposed. Mr. Mackenzie asked me, "What about the \$12?" I think \$12 is equitable. I believe the majority of people of low income can pay \$12. That is a specific amount we will pay and which the provinces will have in hand. I believe the rest of the money should come from the national revenue of the country, as I indicated on a previous occasion, and I have not had any occasion to change my mind in that respect.

Mr. JOHNSTON: Mr. Chairman, I want to thank Dr. Heagerty for answering my question. I think he has taken the view that considering his financial circumstances—he spoke from a personal point of view and we all appreciate that—the contribution as was stated in the first instance, for single persons a total of \$42 and for married persons \$74, was entirely too high, and that he thought from his own personal experience \$12 would be a more reasonable amount to pay. I should like to draw to Dr. Heagerty's attention that his financial circumstances, although he may be retiring in a little while, are going to be a great deal more than the average citizen of Canada. That is why I took the stand so adamantly at the first on these social security proposals that the whole thing should be non-contributory and if we are going to take it out of taxation it should come out of the general revenue for the very obvious reason, as Dr. Heagerty has pointed out to the members of the committee, that it is going to be utterly impossible for the average citizen to pay this amount. It should be spread over the resources of the entire country and, as I say, if you are going to take it out of taxation it should be taken out of the general revenue. Dr. Heagerty has pointed out to us a very material consideration in this matter, the people who have small incomes, as was suggested by Mr. Wright a moment ago, of around \$300 and \$400 a year. When you come to reduce that by \$25, \$50 or \$75 for medical services you cut down their income a tremendous amount. Of course, there may be some who have an income of \$100,000 a year and if you take \$100 off that they never notice it.

Hon. Mr. BRUCE: There are not many of those.

Mr. JOHNSTON: Not unless they would be doctors or somebody like that, but the point is—and I think Dr. Heagerty has very clearly stated it, and I should like to emphasize it—people with low incomes are going to be in a very bad situation when you come to reduce their yearly income by the amount which is suggested here. I think we would be well advised in this committee to eliminate the individual charge entirely and make it non-contributory.

Hon. Mr. BRUCE: Mr. Chairman, we dealt with that last day.

The CHAIRMAN: Yes, it is out of order.

Hon. Mr. BRUCE: I object for one to reversing our decision.

Mr. JOHNSTON: It might be good management.

Mr. DONNELLY: This is sort of a confessional box. We are all telling our own personal experiences. I want to tell you the practical way it appeals to me. We have in my own district at the present time a municipal doctor and it is sort of a health insurance system. He goes all over examining school children, inoculates them, vaccinates them, and so on, looks after their health. He does all the major operations and charges just one-half the fee. In other words, we hire a medical man. He does all the medical work. He does half, you might say, of the major operations because he only charges one-half the fee that is allowed in the province, and he does health work with regard to the children in the schools. In the municipality there are about a thousand people over 16 years of age and we pay the doctor \$5,000. That is \$5 a person.

Mr. JOHNSTON: Do you consider that is a good salary for a doctor?

Mr. DONNELLY: Yes, that is quite satisfactory. Of course, he gets a lot more. The doctor who is in my district at the present time is doing outside work, other operations, and he is probably running around \$12,000 or \$13,000. However, he does this work for that amount of money. What are we going to get for the extra amount of money because we are going to pay another \$7 a year? We are going to collect that from the individual. That is another \$7,000 we are going to collect. Then we are going to pay another \$100,000,000 from the federal government for it, too. We are going to collect another \$50,000,000 from the income tax. What are you going to get for that which amounts to another \$15 or \$16 per individual? What are you going to get for it? All we are going to get is hospital attention. We are going to get that paid. We are going to get the other half of a major operation. One half is paid already. We get the other half. We still have attendance, care and so on. I think we are paying too much for what we are going to get extra, in some way, although I do not know how it comes about. It seems to me that the cry is going to go out that we are paying far too much for what we are getting extra. That is the way I feel about it.

Mr. JOHNSTON: Do I understand you to say that \$5 is the amount that was paid under the municipal scheme?

Mr. DONNELLY: The premium.

Mr. JOHNSTON: That covers all expenses?

Mr. DONNELLY: We collect \$5,000 from the people in the municipality for the fee for the year.

Mr. JOHNSTON: That takes care of the whole thing?

Mr. DONNELLY: That takes care of the doctor. There are about 1,000 people over sixteen years of age, which means \$5 from every individual over sixteen years of age.

Mr. HOWDEN: What about hospital expenses? Does that come in the \$5?

Mr. DONNELLY: No. He has to pay the hospital bill and one half the operation.

Hon. Mr. BRUCE: Is not nursing extra?

Mr. DONNELLY: Yes. Nursing goes into the bill. We have a hospital there which charges the usual fee, and they get whatever nursing is needed thrown in with the hospital unless it is a serious case and you want a private nurse.

Mr. McGARRY: Do you have the service of a specialist?

Mr. DONNELLY: No. If you are not satisfied with your doctor and want to get somebody else, you pay for him yourself.

Mr. SLAGHT: I want to reiterate the warning I gave at an earlier meeting, that the people of Canada will not be prepared to accept this and will not support it in its present form. I am greatly fortified in that view by what Dr. Heagerty told us to-day. Take the schedule here. Take a married man with an income of \$1,800 a year; the total you are asking him to pay is \$54. His income tax aside from this is twice \$172. He is paying \$354 now and you are going to put another \$54 on top of that by way of income tax. Then we come down to the foot of the schedule. You have a \$74 maximum, as I understand it. Is that right, Mr. Bryce?

Mr. BRYCE: Yes, sir.

Mr. SLAGHT: A man whose income is \$2,200 is asked to pay \$74 and a man whose income is \$10,000 or \$20,000 a year pays the same \$74. The people will not stand for that.

Mr. McCANN: He is getting the same services.

Mr. SLAGHT: I know. But a man whose income is \$10,000 a year pays the same \$74 as a married man at \$2,200 a year pays for the medical services. That is contrary to what I thought was the established principle in Canada with regard to taxation, namely, to let those who are best able to pay carry the burden.

Mr. McGARRY: The man in the high category is only getting the same services.

Mr. SLAGHT: I know he is getting the same services. But if he is better able to pay, why should he get the same services as the man with the \$2,200 a year? I am going to oppose that as far as I can.

Mr. WRIGHT: I must agree with Mr. Slaght with respect to that. Some of the members have stated that the man with the high income is getting the same services. Well, he is getting the same service but he is paying more to-day for that service. At least I have heard people who are in the high income groups say that they have had the same operation as some one in the lower income group and paid twice as much for it.

Mr. HOWDEN: Hear, hear. So they should.

Mr. WRIGHT: That is the situation to-day. But you are getting away from that under this bill. The man in the high income group under this bill is the man who is going to benefit by it, because he is getting away from those additional charges which he has paid in the past to carry the fellow who is unable to meet those expenses. I think we have to take that into consideration.

I would also say a word with respect to what Dr. Donnelly has said regarding our municipal health schemes in the west. There is a municipality in my constituency which gives complete medical health services—hospitalization, major operations, specialists, but not dentistry at all. They do it at a cost of approximately \$9 per individual. They have a special agreement with some of the specialists in Saskatoon and Regina whereby any specialist operations that are necessary are obtained at 50 per cent of the regular fee. I believe the medical association censured certain of their members who entered into that agreement. They also had an agreement with a surgeon in a local hospital—and a very good

surgeon—whereby he performed all the operations for that municipality for a fee of \$250 per month. I know that in that municipality I have met considerable resistance to this bill because of the fact of the additional cost that it is going to mean to them. If we wish to get a medical health bill through that is going to be satisfactory to the people of Canada, we have to take some of these things into consideration; and we will have to lower that initial charge to a point where the average person in this country is going to be able to meet it. Otherwise we are wasting our time.

Mr. McIVOR: Mr. Chairman, with your permission I should like to ask Dr. Donnelly a question. Are these patients in a city, a town or a village or are they scattered all over the community?

Mr. DONNELLY: They are scattered all over the community.

Mr. McIVOR: It would cost more for the doctor to visit them than it would if there were a thousand of them, say, in one concern like the Canada Car at Fort William?

Mr. DONNELLY: Of course he has the driving to do as well.

Mr. McIVOR: He is not paid extra for the driving?

Mr. DONNELLY: Oh, no.

Mr. McIVOR: That was the contention that this committee of railway men took up with me. They said, "We can do it far better outside of the health insurance bill. These things you are going to give to us we do not want because a man and his wife would pay \$74 a year, which we can get better through our municipal scheme." I did not know just how true it was.

Dr. HEAGERTY: It should be pointed out or you should realize that children and indigents are included free, so that the comparison is not a fair one.

Mr. DONNELLY: He looks after the children too.

Dr. HEAGERTY: Not under the scheme that was referred to.

Mr. DONNELLY: Oh, I beg your pardon. But in the municipal scheme he looks after them.

Dr. HEAGERTY: Oh, yes, I know that.

The CHAIRMAN: Is there any further discussion?

Mr. McCANN: May I ask Mr. McIVOR a question: Are you in favour of the principle of health insurance?

Mr. McIVOR: I am in favour of contributory health insurance.

Mr. McCANN: I thought so.

Mr. McIVOR: I think it is a good thing. But I think the government should bring it into the place or take it into the place where everybody could take advantage of it. If Saskatchewan can get what they are doing for \$5 a year, why cannot the dominion come pretty close to that, because in Saskatchewan the population is scattered. It surely can be done far cheaper where patients are nearer together.

Mr. HOWDEN: May I point out, with regard to Saskatchewan, that it is a matter of contract between the doctor and a group of people, whereas this is not. What we propose to submit to the Canadian people is not a contract business at all. It is a matter in which the people have the liberty of calling the doctor they wish, and it is an open matter for the people and the medical profession. You can go to any institution at all. They hire a doctor on contract on the basis of \$1 a month, to look after the employees, which is a totally different thing from getting full medical service that is obtained here.

Hon. Mr. MACKENZIE: I should like to ask Dr. Donnelly if he knows what the terms of the new proposed bill in Saskatchewan are. Have you seen it, Dr. Donnelly?

Mr. DONNELLY: No, I have not.

Mr. McCANN: I was just going to speak along the same line as Dr. Howden spoke, when he said that the services which will be given under the proposed bill are not comparable at all to what they are getting under the municipal doctors scheme. In addition to the personal service, you have hospitalization, obstetrical service, dental service, pharmaceutical service and nursing service. For \$5 perhaps they are getting fair value; but if you are going to get greater value for the amount of the contribution and the cost that there will be under this new scheme, I think that at least should be submitted to the people in order to see whether or not they will be favourable to it. I am firmly of the opinion when they see what these increased services are going to be, and compare them with what their budget has been throughout the years for all these services, they will consider that they are getting a good bargain and getting good service for this money.

Mr. DONNELLY: But you must remember that we are collecting \$21 and something per individual.

The CHAIRMAN: \$21.60.

Mr. DONNELLY: Whereas we are collecting \$5 now. There is \$16.50 we are going to pay extra. What are we going to get extra? Are we going to get \$16.50 more value? I do not think so.

Mr. McCANN: I think Dr. Donnelly, as an old practioner, will agree with me that when it comes to the matter of expenses due to sickness, the doctor's fee is the small proportion of that expense. Hospitalization, nurses, drugs and all the rest that goes with it are the heavy items of expense in a severe illness in a family.

Hon. Mr. BRUCE: I should like to support what Dr. McCann has said. I think he has put it very cleary and accurately. Is it not a possibility that we are attempting too grandiose a scheme? We could eliminate some of the benefits and reduce the cost. Perhaps we could compromise by giving a service such as Dr. Donnelly has suggested. Then the cost will come down. But if you are going to give everything that is contemplated within this bill, I do not think the cost is too much. I need not repeat what Dr. McCann has said, because he has covered that issue. Further, I should like to add that I pointed out some time ago that some consultation with the provinces is very essential. Might it not be better, before we conclude the financial part of this bill, to have that conference, and in the meantime get on with the other portions of it now?

The CHAIRMAN: I was just going to make a suggestion.

Mr. MAYHEW: That is the suggestion I was going to make. I made it some time ago. I think we are starting at the wrong end of the bill. I think that we should consider the bill itself and just what we are willing to pay for what we are getting. I should like to see the horse before I buy it.

The CHAIRMAN: I wish to make this suggestion to the committee. Would it be satisfactory to the committee, without taking a vote on these amounts or attempting to specify what in the opinion of the committee the amount or method should be, to have presented to the provincial ministers' conference a very brief and concise statement embodying or setting forth all the proposals that have been made here to-day, without specifying our priority opinions, and getting their reaction to that? Then we can discuss later the final terms.

Mr. LOCKHART: That is fine.

Mr. HOWDEN: To clarify matters, Mr. Chairman, I will withdraw my motion and leave the record clear.

The CHAIRMAN: Thank you, Dr. Howden. My own sense of the opinion—it may be worth nothing, of course—is that there is a very strong leaning towards the \$12 flat rate and abolition of the contribution by means of income tax. That is my own sense.

Mr. WRIGHT: Hear, hear.

The CHAIRMAN: Is the suggestion I have made satisfactory?

Mr. MAYHEW: Even the \$12 is more than many families are paying to-day, who are in company health insurance schemes.

The CHAIRMAN: That will be pointed out in the statement made to the provincial conference. Is the suggestion satisfactory?

Some hon. MEMBERS: Agreed.

The CHAIRMAN: Then the next thing, I suppose, is to get on with the bill. Is that right?

Some hon. MEMBERS: Hear, hear.

The CHAIRMAN: Is it your wish to proceed now or shall we adjourn and take it up next time?

Mr. DONNELLY: I move that we adjourn.

The CHAIRMAN: It is nearly 1 o'clock.

Mr. DONNELLY: Take it up at the next session.

The CHAIRMAN: Then we will adjourn to the call of the chair.

The committee adjourned at 12.45 p.m. to meet again at the call of the chair.

APPENDIX "A"

CHRISTIAN SCIENTISTS ASK FOR PROTECTION AGAINST POSSIBLE COMPULSORY ACCEPTANCE OF MEDICAL TREATMENT UNDER THE NATIONAL HEALTH ACT, AND ALSO THAT CHRISTIAN SCIENCE TREATMENT BE ACCEPTED AS A BENEFIT FOR CHRISTIAN SCIENTISTS UNDER THE ACT.

The members of the Christian Science Churches of Canada appreciate the privilege you have extended to them of making further representation regarding the proposed Health Insurance Bill, and, indeed, they recognize that unless special provisions are made to protect fully their religious rights and liberties, inherent in common law and long since recognized by statutory enactments in most of the provinces of the Dominion, the enforcement of the Act as at present drawn will lead, unintentionally perhaps but nevertheless remorselessly, toward the overthrow of their religion. This result would be contributed to by (1) the possible enforcement of acceptance by Christian Scientists, contrary to their religious convictions, of medical or surgical ministrations or treatment, (2) by forcing the Christian Scientist to pay a heavy tax for medical treatment which he cannot and will not accept and providing no compensating assistance in securing that Christian Science treatment upon which his health and at times his very life actually depend, and (3) by indirectly forcing the Christian Science practitioner to discontinue his religious healing practice by having thus denied to him, in large part at least, the one and only source of income which he has, namely compensation from his patients or parishioners, and at the same time heavily taxing him for services which he and his patients cannot accept.

Recent statements by the Department of Justice and decisions made by your Committee and/or officials of the Department of Pensions and National Health regarding the earlier presentation of our case make further representations at this time necessary. We trust that witnesses will be heard orally and as a preliminary step this written memorandum is respectfully submitted.

The practice of Christian Science and the dependence upon that practice for the cure of human ailments is legal at common law in all the provinces of Canada and it has been specifically recognized in the statutory law of six of those provinces. If our request of the Federal government that Christian Science receive special consideration under the proposed Health Insurance Act has the appearance of newness or strangeness to Federal lawmakers, it is only because in the past such legislation has been exclusively a provincial matter and this is the first occasion on which it has become a Federal subject matter. For example, in Ontario, the rights of the Christian Science practitioner and patient against interference by public or medical authority or the acceptance of compulsory medical care has been recognized for over twenty years; and in that time there have been five different and specific occasions in which the Ontario government has recognized and protected this religious freedom by special clauses inserted in Acts or Regulations relative to health.

In the brief which we presented last June to the Special Committee of Parliament on Health Insurance we respectfully asked that the members and adherents of the Christian Science Churches of Canada be exempt from compulsory acceptance of medical or surgical ministrations or treatment under the Act and accordingly from enforced payment of contributions.

But let us first consider the former of these two requests namely the exemption from compulsory medical treatment. At that time we pointed out that every citizen of the Dominion would be required to register not only for

the purpose of contributions, but also for the purpose of selecting a doctor, and that if he did not voluntarily select a doctor his name would nevertheless be placed upon a doctor's list. See Section 11, subsection (2) (e) which provides for "the distribution among the several medical practitioners whose names are on the lists....of the qualified persons who after due notice have failed to make any selection...." So the individual Christian Scientist would thus find himself on the list of a certain doctor, against his own wish and without his consent. The question which naturally arises is this, after he is placed on a doctor's list what is the relationship between that doctor and the Christian Scientist. The answer is found in the Summary of the Act which states "The physician would have a responsibility for the health of each member of the family and he would be responsible for public health measures designed to reduce morbidity and mortality. He would act as counsellor, advisor and supervisor in respect of the health of the whole family as a unit." And so the physician is to be *responsible* for the health of each member of the family! Is it not obvious that responsibility involves authority? Can a doctor be held responsible for that over which he has no authority? Obviously such quotations could be interpreted as implying compulsion. Nevertheless at that June meeting with your Committee we were told that there was no compulsion in the Act. This opinion that there is no compulsion in the Act was concurred in by the Department of Justice in a statement made in January of this year, and is recorded in the Minutes of the meeting of the Special Committee on Social Security held on March 1. With these opinions regarding the strict wording of the Act itself we can perhaps agree, but it must be remembered that the Bill presupposes further or additional provincial enactment which may vary considerably from the draft Health Insurance Act as set forth in the second schedule of the Bill. In fact the Bill itself may be brought into the courts some time in the future for interpretation. Moreover, the Bill and the draft Health Insurance Act confer the widest powers for the making of regulations which will have the force of law.

In particular we would direct your attention to Section 11, subsection 2 which says "The regulations and arrangement aforesaid shall be such as to secure that qualified persons shall, subject to the provisions of this Act, receive from medical practitioners with whom arrangements are so made all such adequate measure for the prevention of disease, and all such proper, necessary and adequate medical, surgical, and obstetrical treatment, attendance, and advice as may be prescribed." In view of this statement and several other references to regulations, it might at some future time be difficult indeed to maintain that a regulation compelling the acceptance of some medical ministrations or treatment is in excess of the powers conferred.

In view therefore of what may be deemed to be the broad purposes of the Act, namely to maintain or improve the health of the nation by securing the acceptance by everyone of medical care, both preventive and curative, together with the power conferred for the making of regulations to carry out these purposes, the latitude given in the drafting of the provincial measures and the possible interpretation of the Act by the courts at a later date, the Christian Scientists of the Dominion feel justified in asking for, and in urging the imperative necessity for the insertion of a clause in the Act to ensure that there shall be no compulsion to the acceptance of benefits.

Recently we were privileged to bring to the attention of the Department of Justice this question of future provincial enactments and regulations and were then informed that in view of this larger picture, the Department of Justice saw no reason why a clause protecting against compulsion should not be included in the Act and that they would so advise the Department.

Furthermore we have reason to believe that it is the unanimous or almost unanimous wish of the members of the Committee at the present time that no one be compelled under this Act or its regulations, or under any enactment towards which the Dominion government contributes, to accept or to submit to physical, medical or surgical ministrations or treatment contrary to religious conviction. All that remains to give effect to your wish is that it shall be so stated in the Bill. We will be grateful for such a clause either in a form which gives general reference to everyone or special reference to the members and adherents of the Christian Science Church.

* * * * *

In the brief presented last June as stated above, we asked not only that Christian Scientists be exempt from the compulsory acceptance of medical treatment under the Act but also that they be exempt from the obligation to contribute for such treatment. Recently we have been informed that the latter request is not to be granted.

We accept that decision, as indeed we must, but in so doing and in protection of our religious rights and liberties, long established and recognized, we claim the right of Christian Scientists to receive in return for such enforced payment benefits of a nature such as they can accept and which are not contrary to their religious convictions.

We respectfully request that Christian Science treatment be recognized as a benefit under the Act for duly accredited Christian Scientists.

The Bill makes provision for the supplying of medical, dental, pharmaceutical, hospital and nursing benefits, supplemented only by such ancillary services as may be prescribed by the doctor. This makes no provision whatsoever for those who desire and require the assistance of Christian Science treatment. Surely, the Committee in endorsing such a measure has not noted that it is denying to those individuals who depend upon spiritual means the cost of their healing ministrations while giving it to those who rely upon material means.

It should be understood that Christian Science treatment is not, in practice, something that is only supplementary to and running concurrent with medical care. It is a complete system of prophylactic and therapeutic care embracing as it does the divine methods of prevention and cure. The individual receiving Christian Science treatment is not under medical care and vice versa.

Accordingly, the acceptance of Christian Science treatment as a benefit for Christian Scientists would not be a duplication of service. In perhaps 95 per cent of all cases, Christian Science treatment will be depended upon wholly and exclusively, and it should be available under the Act. In those very infrequent cases where the assistance of a surgeon is required, such as in the setting of a broken bone, et cetera, and with the desire to avoid duplication of cost, it can be agreed that the surgeon's services only shall be chargeable to the fund.

We recognize that in determining the right to Christian Science treatment under the Act, and also the approximate cost of this treatment, the claimant must accept a yardstick which is understandable to the government, and which can be applied in the administration of funds under the Act. Therefore we are willing that an individual, desiring to have Christian Science treatment and have it paid for by the fund to which he has contributed, shall establish his right by medical diagnosis, which, for the purposes of the Act, will do two things—(1) determine the nature of the complaint and need of treatment and (2) give guidance as to approximate cost (average costs as in the practice in the Workmen Compensation Acts, etc.)

This medical diagnosis to establish the necessity of treatment and also to determine the approximate cost should be limited definitely to diagnosis only and should not include or imply advice or supervision. It will be accepted by Christian Scientists because, while they have confidence both as to the efficacy of Christian Science treatment and its cost and the certainty of no malingering, it is only fair that the Committee's fears on such matters be recognized and safeguards established, to establish (1) the definite need for treatment and (2) that the costs will not exceed the average cost of similar cases treated medically.

With our religious rights and privileges so protected, the Christian Scientist could secure the treatment he requires under the provisions of the Act on an equality with the individual accepting medical care, and, at the same time, the charge against the fund not exceed, and would generally be less, than charges in similar cases treated medically. Moreover, and this point should appeal alike to all—to those who have actual knowledge of the efficacy of Christian Science treatment and to those who may have some reservations—the Government will have a definite record of the health of Christian Scientists and if that health is lower or the costs higher than that of corresponding classes receiving medical benefits, the Act can be amended accordingly.

The observation of Sir William Fletcher Barrett, F.R.C.S. at the time of the passing of special exemption for Christian Science Nursing Homes in Britain, will, I am sure, prove to be equally applicable to Canada under its Health Act. He said, "I am bound to say that cures, often of a very remarkable character, are effected" and "the marvellous improvement in the general health of persons who have become adherents of this faith is unquestionable."

The recognition of Christian Science treatment as a benefit under the Act is necessary not only for the patient, but also for the Christian Science practitioner. Without the labours of these devout people, the healing ministry of Christian Science would largely cease to function. Failure to include Christian Science treatment as a benefit under the Act would be a serious blow to the Christian Science religion.

The *Christian Science Journal* gazetted practitioner is one who after due tests is officially recognized as a public practitioner of Christian Science. He must have voluntarily renounced all commercial or other interests, and devote himself solely and exclusively to the spiritual ministry of healing the sick. Therefore he has no income from other commercial or professional pursuits. Furthermore he is not an employee of the church nor does he receive from it any salary or honorarium for his public ministry. His only income is the revenue received directly and exclusively from his public practice of Christian Science healing. Any absorption by the Government of funds which individuals normally pay to the Christian Science practitioner for his services would directly interfere with his income. As he has no other source of revenue it might eventually force him to discontinue his Christian Science practice.

But the results would reach far beyond the practitioner and his patients and would vitally affect the church organization itself, for through the practitioner's office passes that constant stream of sick and suffering people who, having exhausted material remedies, seek healing through spiritual means, and who, having received healing, become active adherents and then members of the Christian Science Church. To interfere directly or indirectly with the right of the Christian Science practitioner to maintain himself in the practice of Christian Science, would strangle the Christian Science organization, the holy purpose of which is to re-establish primitive Christian healing among men.

To add irony to the situation, the Christian Science practitioner himself would be compelled to contribute by taxation to the Act which may remove him from the sacred ministry to which he is devoting his life and which may overthrow the church which he so faithfully serves.

Nor has the Christian Science Church, its members and adherents, or its practitioners done anything for which they should be so penalized. Nothing has been done other than that they have utilized that most cherished of British and Canadian traditional rights, namely the freedom to worship God in accordance with the dictates of one's own conscience.

We therefore ask that the Act be so drawn as to grant the right of any qualified person on behalf of himself and his children, and of any adult dependent, to receive treatment in accordance with the established practice of the Christian Science Church by a Journal gazetted practitioner of that Church whom he may choose *in substitution for* medical treatment as provided in the Act, and to have the Christian Science practitioner paid at a rate corresponding to the payment of a medical practitioner in like case; and in order to meet the practical difficulties which might arise we are satisfied to have it provided as a prerequisite to payment that the need for treatment be established by the patient first submitting his complaint to the diagnosis of a medical practitioner.

We respectfully submit to you a clause to be inserted in the Act which embodies the two points herein discussed, namely,

- (1) the protection against compulsory acceptance of medical or surgical ministrations or treatment.
- (2) the providing of Christian Science treatment as a benefit under the Act for those qualified persons whose bona fides are duly established.

The clause reads as follows:—

As an enjoyment or exercise of religious freedom, it is provided that nothing in this Act shall be deemed and no regulations shall be authorized to compel any qualified person and/or some or all of his children and others dependent upon him for whom application for exemption is made (accompanied by a certificate of his and/or their membership in or adherence to the Christian Science Church signed by the provincial Christian Science Committee on Publication for the province of residence) to accept or to submit to physical, medical, or surgical ministrations or treatment contrary to his or their religious convictions, and it shall be the right of any qualified person on behalf of himself and his children and of any adult dependent, when so certified, to submit his or their complaints to medical diagnosis and should illness be so established to receive treatment in accordance with the established practice of the Christian Science Church by a Journal gazetted practitioner of that church, whom he may choose, in substitution for medical treatment as herein provided and the practitioner shall be paid on a rate corresponding to that of a medical practitioner hereunder in like case; but not so as to affect his obligation to observe laws and regulations respecting sanitation, infectious and communicable diseases, and quarantine.

Recognizing the inadequacy of a written document in connection with such an important matter, we would respectfully request the privilege of presenting our case orally.

Sincerely yours,

JAMES W. FULTON,

*Christian Science Committee on Publication for Ontario,
on behalf of the Christian Science organization for the
Dominion of Canada.*

APPENDIX "B"

FURTHER BRIEF TO THE SPECIAL COMMITTEE ON SOCIAL SECURITY OF THE HOUSE OF COMMONS SUBMITTED BY THE DOMINION COUNCIL OF CANADIAN CHIROPRACTORS.

To the Honourable Cyrus Macmillan, Chairman of the Social Security Committee and the Members of the Committee:

On June 4, 1943, on behalf of the Dominion Council of Canadian Chiropractors, I submitted a brief asking that the profession of Chiropractic be recognized by the Committee and placed on an equal basis with the medical profession in the Health Insurance Act. Since that time there has been a tremendous demand by the public of Canada urging our Council to take every step possible to protect their rights by a provision that those who pay for Health Insurance benefits be granted freedom to seek health services where they wish.

On our previous presentation we were allotted $1\frac{1}{2}$ hours. This was only a fraction of the time necessary to present our case. Mr. Cleaver, a member of the Committee, pointed out that he was convinced that a large section of our population have had highly beneficial results from such treatments and in view of that he thought great care should be taken and the fullest opportunity be given for representations of our Association to fully present their case (page 498, lines 1-9). He mentioned that the Committee took many days with the recognized medical men. Dr. Sturdy then, on the invitation of the Chairman, said he would be available for further consultation by the Committee at any time. We fully expected to be given this further opportunity but since this has not been made possible we must try to be satisfied with this additional written brief which is herewith presented on behalf of the citizens and taxpayers of Canada and the members of the Chiropractic profession, some 668 in number, in Canada. We deem this a vital public question and worthy of the greatest care and consideration by this Honourable body.

We have on hand some 400 affidavits and statements covering practically all common diseases from patients across Canada certifying as to their recovery under Chiropractic treatment when orthodox medicine had failed. Most of these have been received since our presentation last June.

In our previous evidence we stressed the fact that at least 13,000 spinal adjustments are given daily by Chiropractors in Canada and that some 200,000 persons avail themselves of Chiropractic benefits yearly. We submitted further that Chiropractic has had an unparalleled success in the treatment of disease and quoted some comparative statistics in proof of this position. Chiropractic is in fact, the second largest healing profession in Canada. Furthermore, four provinces in Canada, namely; Ontario, Saskatchewan, Alberta and British Columbia have passed legislation recognizing Chiropractic as a profession and conferring by Government authority the right of Chiropractors to regulate their profession and administer to the health needs of the people of those Provinces. Of 668 Chiropractors in Canada at the present time five-sixths or a total of 571 practise in Provinces having Chiropractic legislation.

Notwithstanding this, the Dominion Government, by unjust discrimination, has nullified to a great extent the rights and privileges conferred by the Provinces. The Health Insurance Act has been redrafted since the last session of Parliament and again submitted to this Committee. Despite our presentation, no recognition of any kind has been accorded our profession and it is left as in

the original Act. This is in line with the treatment meted out to the profession by this Government in all phases of our activities. We submit herewith instances of discrimination in other aspects of the relation of the Chiropractic profession to the public of Canada.

CHIROPRACTIC NOT CONSULTED IN PREPARATION OF ACT

In the preparation of the present Health Insurance proposal, the officers of the Health Department consulted many organizations and in presenting the subject to the Committee the Minister of National Health says, (Minutes, session 1943, page 13): "Just to show how thoroughly the inquiries were conducted, let me list the organizations which were consulted:—

- The Canadian Medical Association
- The Canadian Dental Association
- The Canadian Pharmaceutical Association
- The Canadian Hospital Council
- The Canadian Nurses' Association
- The Catholic Hospital Association
- The Canadian Public Health Association
- The National Council of Women
- The Catholic Women's League
- The Federated Women's Institutes of Canada
- The Federation of French Canadian Women
- The Canadian Welfare Council and Canadian Association of Social Workers.
- The Trades and Labour Congress of Canada
- The Canadian Federation of Agriculture
- The Canadian Manufacturers Association
- The Canadian Life Insurance Officers' Association".

The Chiropractic profession was not consulted. We suggest that no Association is playing a more vital role in the health of the people of this country than the Chiropractors. Many of the Associations listed above obviously occupy an inferior position in health matters. The Department knew or should have known through considerable press reports that the Dominion Council of Canadian Chiropractors had held a meeting in the Chateau Laurier at Ottawa a few days previous to that of the Canadian Medical Association in January, 1943, when Health Insurance was thoroughly considered by that body. Despite these considerations no invitation was extended to the Chiropractors to in any way assist in the preparation of this Act which affects every citizen of Canada, not only in regard to health, but by compulsory financial support.

The reason is obvious. The Medical profession, having a preponderance of representation on these committees, has attempted to create the impression that Chiropractic has little or no value in the treatment of disease and is in fact in some respects a menace, when the reverse is actually the case. About eight years ago statements were made by physicians and surgeons to us that the American Medical Association was then framing advanced legislation which would eliminate all unorthodox competitors in health matters and would leave them a clear field inside of twenty-five years.

ORDERS-IN-COUNCIL ADVERSELY AFFECT CHIROPRACTIC PROFESSION

The war has unfortunately contributed considerably to the means to accomplish this end. By the operation of the Medical Procurement and Assignment Board, extended later to include dentists and nurses, the way has been opened up for special concessions and privileges to be granted to the medical profession by Orders-in-Council. This is accomplished so subtly that the public is unaware of these encroachments on their liberties.

CHIROPRACTIC TRAINING AFFECTED BY WAR

The war has not adversely affected the enrolment of medical students. In fact it has stimulated medical training to the extent that the Government pays the tuition of medical students for the first two years of their course, then they are absorbed in the army and receive soldier's pay for the last two years.

Consider the position of the students studying Chiropractic. They and their instructors are taken out of college by the draft to such an extent that more than one-half of the colleges have closed their doors since the beginning of hostilities. We claim that the Health Insurance Act will give unlimited medical control and further complete this process of a medical monopoly.

CHIROPRACTORS, AS A PROFESSION, EXCLUDED FROM ARMY

The treatment of Chiropractors in reference to the armed forces of Canada is another glaring example of unjust discrimination. At the beginning of the war Chiropractors offered to enlist as privates; they offered to go under age and over the age limit provided they could practise their profession and bring the advantages of their skill and training to the members of the armed forces requiring their attention. This was refused and Chiropractors were drafted to serve as ordinary soldiers and we find that girls are given a six month's course at the universities in physiotherapy and emerge with the rank and dignity of 2nd Lieutenants.

At the beginning of the war the Defence Department announced in the press that the citizens of Canada would be classified and used in those positions for which they were best adapted to contribute to the maximum war effort. Despite this, Chiropractors serve in the ranks and the civilian population and the members of the armed services are both denied their services.

There is now a dearth of Chiropractors. Forty-three per cent of the patients of those practising are shipyard workers, munition workers or engaged in some other essential war services. They come to Chiropractors after medical treatment has failed and are quickly restored to health and return to their occupations.

We have been informed that there are sixteen training centres in Canada giving health services in the rehabilitation of discharged soldiers, airmen, and sailors. Every healing profession, medical doctors, dentists, masseurs, physiotherapists, etc., are represented except the profession of Chiropractic, which is the most essential of all in the rebuilding of these shattered nervous systems.

SOLDIERS' SICKNESS ALLOWANCE REFUSED CHIROPRACTIC

Soldiers' wives and families besiege Chiropractors' offices to obtain compassionate allowances in cases of serious and costly illnesses. These allowances are readily granted for medical benefits but are refused for Chiropractic. These are mothers, wives and children whose sons, husbands and fathers are fighting valiantly for their country. They are deprived of these benefits and either forgo attention or are dependent on charity simply because they have found Chiropractic to be of greater benefit. Chiropractors throughout Canada, from motives of patriotism, are repeatedly giving their services free to members of the armed services and their families rather than see these people suffer through unjust discrimination. We have found numerous instances where soldiers have had to resort to subterfuge to escape penalties which have been threatened by Medical Officers if they themselves are suspected of taking Chiropractic treatments.

HOSPITALIZATION

The public again suffers where hospitalization is required. In these institutions, built and operated by taxpayers' money, patients and their families are denied the services of Chiropractors. The same is true in regard to asylums and public sanitariums.

INCOME TAX EXEMPTIONS REFUSED FOR CHIROPRACTIC SERVICES

In the field of income tax citizens of this country who benefit from Chiropractic are again penalized. Section 5 (n) of the Income War Tax Act provides that a taxpayer may deduct that portion of medical expense in excess of five per centum of his income, if payment is made to any "Qualified medical practitioner, dentist or nurse registered under any Dominion or Provincial legislation . . . in respect of . . . illness . . . of the tax payer". Thousands of patients are imploring Chiropractors to take steps to have this injustice removed. A news dispatch from Ottawa, datelined last Monday, March 27, 1944, announced that fees paid to osteopaths may now be included in medical expenses for the purpose of income tax exemptions according to a new ruling of the National Revenue Department. To illustrate the discrimination and injustice in this respect we need only point out that osteopaths, the majority of whom are in Ontario, are registered under the same Act as Chiropractors in that Province. Here then we see osteopaths and Chiropractors in Ontario practising side by side under the same Act and with equal representation on an administrative Board. Osteopaths are now recognized. Chiropractors are not, and yet Chiropractors with a registration of 417 in Ontario outnumber osteopaths, with 125, better than three to one. This is another discrimination against Chiropractors where the public pays the penalty.

DISCRIMINATION IN TIRES AND GASOLINE

When it was found necessary to ration automobile tires and gasoline, medical doctors, and trained nurses, whose duties are only ancillary to doctors, were allowed permits to acquire new rubber tires for their automobiles and special gasoline privileges; Chiropractors were not. Similarly, Chiropractors were placed under the lowest category in gasoline rationing. It is just as important that Chiropractors use automobiles in visiting bedridden and serious cases as the medical profession, particularly in rural districts. Subsequently, however, an arrangement was made where second-hand tires may be obtained in some instances and after a strong presentation was made through legal advisers in Toronto a higher gasoline category was allowed.

MEDICAL MONOPOLY DANGEROUS

We have cited these instances of discrimination not from motives of self interest but for the protection of the just rights of the taxpayers and citizens of Canada who are the ultimate sufferers. We do not belittle the good work the medical profession is doing. We do think, however, that the Health Insurance Act as presented provides for a virtual monopoly for political medical doctors. It is a closed shop agreement between the Government and the medical profession. This profession through the powerful instrument of the press, which plays up spectacular instances of medical propaganda, attempts to build up its own position and belittle Chiropractic. We cannot accept some of the extravagant claims the medical men are making without reservation. One of these is in reference to the new drug, penicillin. Dr. J. W. McCutcheon, a noted physician and Editor of the *Ontario Medical Review*, in the issue of September, 1943, at page 150, in an editorial, has this to say: "The facts are that penicillin is not proven to be of value in therapy and of cases so far recorded none has exhibited a course which might not be expected in accordance with the natural history of the disease.

"All writings on penicillin that I have seen in both the lay and medical press have tended to accept the proposition that penicillin is a very valuable therapeutic agent. This proposition may be true but it is well to remember that neither bold statement nor wishful thinking make it so. Have you seen

any published account of a control series of cases treated by penicillin investigators? Have you seen any statistics showing a decrease in mortality or length of illness in a group large enough to justify a definite conclusion? What do you as a taxpayer think of the press report that, following the treatment of ten cases under direction of the National Research Council, the Federal Government has handed out two and half million dollars for the manufacture of penicillin?

"It may be everyone is too busy just now to give close scrutiny and careful study to this problem. In my opinion we may be embarking on a huge program of useless expenditure of effort and money unless there is an immediate and comprehensive survey of all available data and the submission of this data to deliberate and clear judgment. One should bear in mind that the burden of proof rests upon those who affirm and that the desire does not alter facts."

This is the opinion of not only an eminent surgeon, but one who is entrusted with the editorship of the official publication of the Ontario Medical Association.

A press report date-lined yesterday, March 29, 1944, in the *Vancouver Daily Province* contains a startling revelation of the injurious and fatal results of the use of the sulfa "wonder drugs". It says, in part: "In Toronto, Chief Coroner Dr. Smirle Lawson has ordered an inquest into the death of a Toronto man from sulfanilamide drug. He said the decision was reached after considering the deaths of 10 persons in Toronto during the past year, all believed to have been caused by taking too large quantities of the drug. . . . Hospital authorities explain that sulfa drugs have been much improved, although anything so powerful as sulfa drugs may, of necessity, bring bad results if not properly controlled."

CHIROPRACTIC SUCCESS AND PUBLIC DEMAND

In our original brief last June we established the following facts:—

"1. Chiropractic is an established and recognized health profession in Canada.

2. The education and training of chiropractors qualify them to treat the ailments, diseases, defects and disabilities of the people of Canada.

3. A large proportion of the population of Canada depend on chiropractic practice for their health needs.

4. The citizens of Canada demand the right to choose their own health practitioner.

5. Chiropractic has had unparalleled success in the treatment of diseases and in the percentage of recovery."

In addition we presented petitions signed by 56,571 voters and taxpayers requesting freedom of choice of health practitioners under Health Insurance. We mentioned that we had at that time 2,940 cards signed by British Columbia citizens in answer to enquiries as to their stand on these matters. 97.61 per cent certified that they had received Chiropractic benefits, 99.1 per cent demanded the right to choose a Chiropractor under the Health Insurance Act, 98.38 per cent wanted Chiropractors in the army and even as large a percentage as 34.1 per cent went on record as saying that they or members of their families had been cured of a disease diagnosed as incurable by the medical profession, and 32.33 per cent had avoided surgical operations considered necessary by surgeons through Chiropractic.

We also referred to the fact that the Trades and Labour Congress of Canada and the Federation of Agriculture had presented briefs requesting recognition of Chiropractic treatment in the bill.

SPECIFIC INSTANCES OF UNPARALLELED CHIROPRACTIC SUCCESS IN
COMMON AND SPECIAL DISEASES

We are sure this Committee recognizes the fact that oral testimony is many times more effective than the printed word. It was our intention, had we been recalled, to have produced witnesses to demonstrate the permanent results being daily obtained by Chiropractors in specific diseases, which diseases, according to general belief, would not respond to Chiropractic treatment. We emphatically believe that had the framers of the Act and the honourable members of this committee any knowledge of the magnitude and scope of the work the Chiropractors are doing in the length and breadth of Canada, we would have been included in the first draft of the Health Insurance Act.

We should like to call the attention of this committee to the fact that extensive research has been conducted by the Palmer Chiropractic Research Clinic, the National Chiropractic Public Health Bureau and the American Chiropractic Research Committee into the subject of the efficacy of Chiropractic in cases of sterility, venereal, infectious and contagious diseases and confinement.

In the Palmer Chiropractic Research Clinic at Davenport, Iowa, Dr. B. J. Palmer has on his staff several qualified registered medical specialists with all the most up to date diagnostic research instruments used by the most advanced scientific medical clinics to-day. This Research Clinic found that in many cases chronic sterility (of five and ten years duration) responded readily and in from 30 to 90 days became pregnant through Chiropractic methods only.

The Research Clinic has also found that where patients are having recurrent miscarriages, it is possible through Chiropractic adjustments to strengthen the organs so that they quickly become normal, healthy and productive.

The Research Clinic has also established that Gonorrhea responds readily to Chiropractic. It is recognized by the medical profession that all persons exposed to this disease do not contract it. The Clinic explains this by proving that in those cases the nerves supplying the organs in question are free from spinal interference and they are able to resist infection. When contracted, Chiropractors release the nerve interference by adjustment and the disease is eradicated.

In contagious and infectious diseases the Research clinics have successfully demonstrated the fact that all febrile diseases respond immediately to Chiropractic. Cases of diphtheria, scarlet fever, small pox and typhoid fever ordinarily run a definite course. Chiropractic shortens the time, very much lessens the severity of the illness and eliminates complications and chronic after effects.

It is found in Chiropractic hospitals that confinements are shortened in duration and made easier by Chiropractic adjustments which increase the nervous energy causing the muscles of expulsion to operate normally without the use of stimulating drugs. They have also found that this method of treatment causes the public arch to separate making it possible to have normal, natural confinements without the use of forceps or having to resort to Caesarean section.

Chiropractic is here to stay. The public demand it in spite of all the obstacles thrown in its way and it will go forward to greater heights of accomplishment and recognition.

CHIROPRACTIC EDUCATIONAL REQUIREMENTS RAISED AND COLLEGE FORMED

Since the presentation of our original brief, the Dominion Council of the Canadian Chiropractors' Association has increased the educational requirements of students by setting a minimum course of study of four years of eight months each in an approved Chiropractic College. At our last hearing Dr. Walter

Sturdy, President, said, "We are going to establish a College right here in Ontario, in Toronto, that will be controlled by the chiropractic Council, by the chiropractors of Canada, where we will teach and turn out students of whom I do not think even our medical brothers would be too ashamed."

At a meeting of our Council in Toronto recently this has taken definite shape and the College is now in the process of establishment and we expect it to be in operation by this coming September.

CONCLUSION

In conclusion we wish to repeat what we said in our first brief at the bottom of page 483, namely, "It, therefore, will readily be seen that before chiropractors are allowed to practise they are well equipped to treat the human body for ailment, disease, defect or disability. They are fully qualified to take complete charge of the sick or injured and if they find that surgery is indicated, being educated in the fundamentals, they do not hesitate to refer these cases to the surgeon just as a medical man refers dental work to a dentist and specialized cases to a specialist."

We have demonstrated beyond any question that Chiropractic should be included on the same basis as medicine in any Health Insurance proposal. Thousands of Canadian citizens would come forward to testify to the lasting benefits which they have received from Chiropractic. Scores have written to us voicing their indignation that the profession has not as yet been recognized in this legislation.

We submit herewith and ask to have attached as appendix "A" to this brief a printed report of a survey conducted by Burton Shields Company, Publishers, of Indianapolis, Indiana, showing the tremendously high percentage of results obtained by Chiropractors in the treatment of 91 of the commonest diseases of mankind.

The skilled Chiropractors across the country have maintained this high standard and Palmer's Research Clinic has substantiated, through its research, that these statistics are based on facts.

We cannot ask to submit to this Committee such a large number as 400 affidavits but we have picked at random from among these 12 affidavits illustrating Chiropractic benefits to different types of diseases. We respectfully ask for their inclusion to be marked as appendix "B" to this, our presentation.

All of which is respectfully submitted.

Dated at Vancouver, B.C., this 30th day of March, A.D. 1944.

JOHN S. BURTON,

*General Counsel, Dominion Council of the
Canadian Chiropractors' Association.*

APPENDIX "C"

DOCTORS' FEES

On Thursday, March 30, the following statement was made by Mr. Johnston at the meeting of the Special Committee on Social Security suggesting that information be put on record regarding present incomes of doctors and probable incomes under health insurance:—

I think we should have some special evidence before this committee to ascertain what the average income of the doctors was and what it will be when this scheme is put into force . . . I think we should have the matter cleared up and some evidence put on record by Dr. Heagerty, the chairman or somebody else, to show exactly what the incomes will be.

It should be pointed out in reply to this request that there are no complete statistics regarding incomes of doctors in Canada. All available statistics are based upon the incomes of salaried physicians and an estimate of the fees of physicians practising on their own account.

Pages 482 and 483 of the Report of the Advisory Committee on Health Insurance bear a statement of the average earnings of physicians and surgeons for the census year 1931. The statement is qualified as follows:—

Pending the receipt of more definite information regarding the income of health professionals, it is probably worth while to base an estimate upon the rate of *salaries* paid during the period of the seventh census. Following in part the method of the National Committee for Mental Hygiene, the *salary* of employed physicians and dentists and other independent professionals is taken as the starting point. It was assumed that forty per cent of the gross earnings were disbursed as miscellaneous expenses. This assumption was made for physicians and surgeons, dentists, opticians and osteopaths and chiropractors.

The average gross earnings of physicians and surgeons were computed on the above basis at \$5,237 per year, the average net income at \$3,142.

As these figures are based upon an estimate and not upon statistical facts, there is no reason to believe that they are exactly representative of the incomes of physicians in Canada at that time. The figures are related to the year 1931; the source, the decennial census of that year. That was a depression year when the incomes of physicians were below normal. Many people were on relief and it became necessary for the provinces of Canada to provide medical care at extremely low rates for indigents. For example, during the period of depression an amount of twenty-five cents per person per month was provided for medical relief by the province of Ontario. Of this amount four cents was allocated to cover the cost of drugs, leaving twenty-one cents for the doctor, or \$2.52 per person per year for medical care. Later, the rate was increased to thirty-five cents per month and, finally, in 1941, to fifty cents per month inclusive of drugs. During this period of the depression, some doctors were on relief. If it is true that during a depression year the gross income of physicians was \$5,237, one can only surmise what it was during a period of plenty.

The same statement indicates that for the same period the earnings of physicians in the United States were nearly fifty per cent greater than in Canada, the net income being placed at \$4,642. *It is clear that the amounts specified should not be accepted as a true indication of the earnings of physicians.*

The following is an estimate by the Bureau of Statistics of physicians' earnings in Canada for the year 1941:—

Personnel in private practice	Total number	Average net rate	Total net earnings	Total gross earnings	Indicated gross rate
Physicians and Surgeons.....	8,600	\$3,076	\$26,451,756	\$44,086,242	\$5,126

The data upon which this is based was computed according to the method outlined on page 482 of the Report of the Advisory Committee on Health Insurance. It is to be noted that the estimated gross rate for 1941 is less than that for the depression year 1931.

The Committee on the Cost of Medical Care in the United States has provided us with the following tabulations indicative of the cost of benefits and of physicians' fees:—

TOTAL EXPENDITURES FOR MEDICAL CARE IN THE UNITED STATES

(All figures in thousands of dollars)

Service	Total	Sources of Funds				Per Capita (1929)
		Patients	Governments	Philanthropy	Industry	
	\$	\$	\$	\$	\$	\$ cts.
Physicians in private practice.....	1,090,000	1,040,000			50,000	8.97
Dentists in private practice.....	445,000	445,000				3.66
Secondary and sectarian practitioners...	193,000	193,000				1.59
Graduate nurses, private duty.....	142,000	142,000				1.17
Practical nurses, private duty.....	60,000	60,000				0.49
Hospitals: operating expenses.....	656,000	278,000	300,000	54,000	24,000	5.40
Hospitals: new construction.....	200,000		100,000	100,000		1.64
Public Health.....	121,000		93,500	27,500		1.00
Private laboratories.....	3,000	3,000				0.02
Orthopedic and other supplies.....	2,000	2,000				0.02
Glasses.....	50,000	50,000				0.41
Drugs.....	665,000	665,000				5.47
Organized medical services.....	29,000	7,790	16,000	210	5,000	0.24
Total.....	3,656,000	2,885,790	509,500	181,710	79,000	30.08

N.B.—Not all of these items would be included in health insurance in Canada.

PERSONNEL IN PRIVATE PRACTICE AND EXPENDITURES FOR THEIR SERVICES

Practitioners	Number	Expenditures		Per Capita
		Total	Per Cent	
		\$		\$
Physicians.....	121,000	1,090,000,000	56.5	8.97
Dentists.....	56,800	445,000,000	23.0	3.66
Graduate nurses.....	118,000	142,000,000	7.3	1.17
Practical nurses.....	150,000	60,000,000	3.1	0.49
Midwives.....	47,000	3,000,000	0.2	0.03
Chiropodists.....	4,900	15,000,000	0.8	0.12
Optometrists.....	20,200	50,000,000	2.6	0.41
Osteopaths.....	7,700	42,000,000	2.2	0.35
Chiropractors.....	16,000	63,000,000	3.3	0.52
Naturopaths.....	2,500	10,000,000	0.5	0.08
Religious healers.....	10,000	10,000,000	0.5	0.08
Total.....	554,100	1,930,000,000	100.0	15.88

ANNUAL PER CAPITA EXPENDITURES FOR MEDICAL CARE IN THE UNITED STATES
1928-1931

Type of Service	United States	Local Communities	Private Purchase	
			White Persons	All Persons
Practitioners (as per above table).....	\$ cts. 15.88	\$ cts. 12.90	\$ cts. 17.50	\$ cts. 16.70
Hospitals and sanatoria.....	7.04	5.99	3.20	3.09
Drugs and medicines.....	5.47	6.65	3.17	3.10
Public Health.....	1.00	0.67		
Miscellaneous.....	0.69	0.61	0.71	0.69
All types.....	30.08	26.82	24.58	23.58

PERCENTAGE COST PER FAMILY

Physicians.....	% 39.8
Dentistry.....	18.5
Hospital.....	13.0
Medicines.....	12.9
Nursing.....	8.1
All other services.....	7.7
	100.0

COMPOSITION OF THE FAMILY'S MEDICAL BILL

Per Cent of the Total Charged for Specified Items, according to Family Income; Based on Data for 8,639 White Families with Known Incomes, Surveyed for Twelve Consecutive Months, 1928-1931.

Family Income	Number of Families	Average Total Charges	Per Cent of Total Charged per Annum for:								
			Physicians	Hospital	Nursing	Dentistry	Medicines	Refractions and Glasses	Secondary and Sectarian Practitioners	All others	Total
		\$ cts.									
Under \$1,200.....	1,336	49.17	44.5	17.7	3.8	8.4	17.6	2.5	3.5	2.0	100.0
\$1,200—\$2,000.....	2,837	66.81	43.6	13.9	4.7	13.5	16.5	2.2	1.9	3.7	100.0
\$2,000—\$3,000.....	2,235	94.84	41.5	14.4	5.0	17.3	14.5	2.4	2.1	2.8	100.0
\$3,000—\$5,000.....	1,196	137.92	39.3	11.6	7.5	20.4	12.7	2.9	1.8	3.8	100.0
\$5,000—\$10,000.....	723	249.35	35.6	10.5	14.6	22.1	9.2	2.9	2.9	2.2	100.0
\$10,000 and over.....	312	503.19	34.7	12.5	13.7	26.0	7.1	2.3	1.7	2.0	100.0
All incomes.....	8,639	108.14	39.8	13.0	8.1	18.5	12.9	2.5	2.2	3.0	100.0

AVERAGE CHARGE PER PERSON FOR MEDICAL CARE IN A YEAR

Based on Data for 38,427 White Persons in 8,639 Families with Known Income, Residing in Communities of Specified Size, Surveyed for Twelve Consecutive Months, 1928-1931.

Size of Community (Population)	Average Charge per Person per Annum in Families With Specified Income						
	Under \$1,200	\$1,200-\$2,000	\$2,000-\$3,000	\$3,000-\$5,000	\$5,000-\$10,000	\$10,000 and Over	All Incomes
	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.	\$ cts.
Cities of 100,000 and over....	17.51	15.42	23.01	32.30	55.97	127.06	32.39
Cities of 5,000 to 100,000....	7.07	13.15	18.54	25.85	62.86	108.39	23.89
Towns of less than 5,000 and rural areas.....	8.25	12.32	18.11	25.25	42.73	83.06	15.80
All communities.....	9.25	13.17	19.85	28.52	54.16	115.37	22.58*

* Based on estimate of cost per individual.

AVERAGE PER CAPITA COST FOR TOTAL POPULATION OF U.S.A.

Service or Commodity	Per Capita
	Expenditure
	\$ cts.
Physicians.....	9.43
Dentists.....	4.29
Medicines.....	3.10
Hospitals.....	3.09
Nursing.....	1.89
Refractions and glasses.....	0.58
Secondary practitioners and cultists.....	0.51
All other.....	0.69
Total.....	23.58†

†Based on average estimate of cost per individual (above) and per family (\$24.58).

The following figures regarding doctors' fees are also provided by the Committee on the Cost of Medical Care:

(1) Average expenditure for medical services—doctors' fees.....	39.8%
(2) California Medical Economic Survey—doctors' fees.....	44.1%
(3) California Depression and Health Study—doctors' fees.....	33.5%
(4) Medical care (general practitioner, specialist and consultant)....	\$12.68
Operations	4.10
Total for illness and operations.....	\$16.78

In a study of Family Expenditures for Medical Care in small cities, villages and farms, covering the year 1936, carried out by the United States Department of Agriculture in co-operation with the Works Project Administration, it was found that \$61 was the cost of medical care per village family having medical expenditures. This represents a per capita expenditure of \$16 per annum. Of this amount an average of 40 per cent, or \$6.40, represents the per capita expenditure for physicians' fees. The amount of expenditure for medical care varied from \$20 in the family income class \$250 to \$499, or \$6 per capita of which \$2.40 would be expended for physicians' fees, to \$157 in the family income class \$3,000 to \$3,999, or \$38 per capita of which \$15.20 would be expended for physicians' fees. Therefore, the per capita expenditure for physicians' fees varied from \$2.40 per capita to \$15.20 per capita. The percentage of families spending for physicians' services rose fairly consistently with income—increasing from 49 per cent in the class \$250 to \$499 to 84 per cent at the level \$3,000 to \$3,999. For the whole group under review (\$250-\$3,999) the median income fell at the \$1,000-\$1,249 level, at which point the per capita expenditure was \$13 or \$5.20 for physicians' fees. The percentage of total family income expended for medical care by this median group was equal to the average percentage of net income spent for medical care by all groups, namely, 4.2 per cent. On the basis of the estimate of the Committee on the Cost of Medical Care, this median group should have expended \$23.58 per capita for medical care or \$9.43 for physicians' fees.

The survey shows that, while farm families spent less than village families for medical care, the percentage of total income expended was greater. The average expenditure for medical care for farm families having such expenditures was \$49.65, or \$11.35 per capita with \$4.54 (40%) being for physicians' fees, as compared with \$61 expenditure for medical care by village families, or \$16 per capita with \$6.40 (40%) being for physicians' fees. The expenditure by farm families for all income groups was low.

In a nation-wide canvass carried out in the United States in 1928-31, a report of which was published in the October 10, 1941, issue of Public Health Reports of the U.S. Public Health Service, it is shown that the number of

cases attended per 1,000 of population was 646·6. The number of medical calls per attended case was 4·2. Of these calls 12·8 per cent were attended by a specialist.

In a study of sickness cost among Metropolitan Life Insurance employees, published on May 13, 1932, it was found that the cost of providing medical care to 8,677 families, comprising 33,796 persons, was \$854,343. The average cost of medical benefits per family was \$98.46, which represents \$25.25 per capita. Of this amount the cost for medical fees per family was \$39.19. The average cost per person for doctors' fees was \$10.05.

The following conclusion was drawn from the study: The figures also indicate that if a collective purchase or reserve system for meeting medical charges should ever be experimented with, the average cost to be met for a family of four or five would appear to be in the neighbourhood of \$100 to \$125 a year.

According to reports of the Associated Medical Services, Inc., Canada, the annual medical fees per patient were \$12.96 in 1939 and \$12.36 in 1940.

On a fee basis it is assumed that under Health Insurance in Canada the average cost per insured person for medical fees will be approximately \$9.50 per annum. This approximates the estimate of the Committee on the Cost of Medical Care of \$9.43.

The following figures represent the average expenditure per person insured in the Hollinger Employees' Medical Services Association for the five year period 1937-1941:—

Doctor	\$15.35*
Hospital	2.83
Nursing .....	.30
X-ray .....	.62
Administration	1.13
Sundries .....	.21†

A similar plan to the Hollinger Medical Plan was introduced for the Ross mine in 1940. The expenditure per person was \$20.38. The group consisted of 550 persons.

In a survey of Family Income and Expenditure in Canada, 1937-1938, covering urban wage-earners' families, it was ascertained that 66·4 per cent of British families reporting had expenditures for doctors' fees. These constituted 34·5 per cent of the total health expenditures. The cost based on families reporting was \$33.60. Of French families reporting 75·8 per cent had expenditures for doctors' fees and the cost based on families reporting was \$27.50. Allowing 4·4 persons per British family, the cost for doctors' fees would be \$7.64 per capita and, allowing 5·3 persons per French family, \$5.70 per capita.

Doctors' Fees per Family According to Cities of Canada (1937-38)
(Dollar Averages)

Charlottetown	19·1	Toronto	17·4
Halifax	25·8	London	23·3
Saint John	22·2	Winnipeg (British)	23·4
Quebec	23·3	Winnipeg (Other)	19·4
Montreal (French)	19·7	Saskatoon	26·5
Montreal (British)	14·8	Edmonton	23·9
Montreal (Other)	13·9	Vancouver	21·0
Ottawa	26·9		

* Based on doctors' accounts determined in a fair fee for service and paid at 100%.

† Included items of laboratory services not supplied by hospital; pathological reports and extras.

The estimated distribution of costs of medical benefits under the draft Health Insurance Bill is as follows:*

Service	Percentage of total cost	Amount paid for each service	
		Per capita	Total
Physician (including general practitioner, consultant, specialist, surgeon, and operations)	44.0	\$9.50	\$106,485,500.00
Hospitalization (exclusive of capital expenditure)	16.7	3.60	40,352,400.00
Nursing (including private duty nurses)	8.0	1.75	19,615,750.00
Medicines (drugs, serums, vaccines, appliances)	11.8	2.55	28,582,950.00
Laboratory services (blood tests, X-ray, etc.)	2.8	.60	6,725,400.00
Dentistry	16.7	3.60	40,352,400.00
Total	100.0	\$21.60	\$242,114,400.00

The estimate of expenditure for remuneration of physicians under a health insurance plan, namely, \$9.50 per insured person, is on a fee basis. It is to be noted that the sum of \$9.50 is allocated for the payment of doctors' fees for each insured person but, as approximately only 60 per cent ($\frac{3}{5}$) of insured persons will require medical care in the course of a year, the unexpended portion of the moneys available for doctors' fees ($\frac{2}{5}$), namely \$3.80 per capita, may be added to the \$9.50, thus making a total of \$13.30 available for the payment

of doctors' fees for each sick person. Of the \$13.30 it is expected that approximately one-third will be expended for operations. The services of the doctor will include medical examinations, treatment of the sick, operations, immunizations and other procedures.

The estimated average number of visits of the practitioner per sick person is 4.2. 40 per cent of sick persons will probably require only one call and 9.7 per cent ten or more calls.

About 12.8 per cent of sick persons require the services of a specialist. 7.4 per cent will probably require operations. Ordinarily about 4 per cent of sick persons require operations but under health insurance this number will probably increase and particularly during the first years that a plan is in operation. About 12 per cent of sick persons require hospitalization annually and of those hospitalized about 62 per cent will be surgical cases.

One of the most important essentials of a satisfactory medical service is adequate compensation for physicians. The training required is long, costly and arduous, the responsibilities exacting. Practitioners should be adequately compensated for their services and their working conditions should be such that high grade men and women will be attracted to the professions and devote their whole-hearted time and attention to their work.

The total paid to all physicians in private practice in the United States in the year 1929 represents an average gross income of \$9,000 per physician. An average gross income of \$9,000 a year would appear to place the physician in a favoured financial group but, after the physician has deducted the expenses of his practice—the cost of equipping and maintaining his office, waiting-room, nurses' fees, automobile, dues to professional societies, subscriptions to journals, maintenance of library, instruments, replacements—approximately \$5,300 remains as real or net income. Thus, nearly 40 per cent of the physician's income is consumed by professional expenses. Professional incomes in the United States range from less than enough to meet expenditures to an amount as great as \$100,000 a year.

The average net income of non-salaried physicians in the United States for the year 1941 was \$5,047.00. This was based on a questionnaire replied to by 1,586 physicians.

* This is subject to further study.

The average net income of non-salaried physicians for the years 1936 to 1941, inclusive, was as follows:

1936.....	\$4,204	1939.....	\$4,229
1937.....	4,285	1940.....	4,441
1938.....	4,093	1941.....	5,047

The average gross income of non-salaried physicians for the years 1936 to 1941, inclusive, was as follows:—

1936.....	\$7,020	1939.....	\$7,261
1937.....	7,276	1940.....	7,632
1938.....	7,053	1941.....	8,524

The returns indicated that the average amount of estimated collectible bills outstanding was \$2,285 at the end of 1939 compared to \$2,594 at the end of 1941.

The average net income of all salaried physicians in the United States for the years 1936 to 1941, inclusive, was as follows:—

1936.....	\$4,387	1939.....	\$4,641
1937.....	4,443	1940.....	5,037
1938.....	4,228	1941.....	5,495

The estimate of \$9.50 for medical fees per insured person does not mean that every physician in Canada will receive this amount for each patient. Under health insurance conducted on a fee basis, some physicians will earn a bare living and others will have a large income as at present. It should be noted, however, that the object of health insurance is not to lower the cost of medical care but to make all known medical services available to every insured individual at the time it is needed.

It is difficult to estimate the cost of medical care on the basis of capitation or salary until such time as the medical profession has expressed a willingness to accept one or other of those methods of payment and has entered into an agreement with the Health Insurance Commission of the provinces respecting the amount of the capitation or salary, but in respect of salary, it is to be noted that the net incomes of salaried and non-salaried physicians in the United States for the years 1936 to 1941 are almost identical. One might deduce from the above figures that the cost of health insurance on a fee basis would not differ greatly from that on a salary basis.

J. J. HEAGERTY,

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SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

(ON)

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 7

WEDNESDAY, APRIL 26, 1944

WITNESSES:

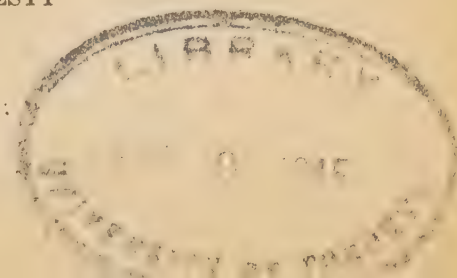
Mr. J. W. Fulton, representing the Christian Science Organization;

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



ORDER OF REFERENCE

HOUSE OF COMMONS,

FRIDAY, 21st April, 1944.

Ordered,—That the name of Mr. Nicholson be substituted for that of Mr. MacInnis on the said Committee.

Attest.

ARTHUR BEAUCHESNE,

Clerk of the House.

MINUTES OF PROCEEDINGS

WEDNESDAY, April 26, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Bourget, Breithaupt, Bruce, Cleaver, Cote, Donnelly, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Lockhart, Mackenzie (*Vancouver Centre*), Macmillan, McGarry, McGregor, McIvor, Maybank, Mayhew, Nicholson, Slaght, Veniot, Wood and Wright.—29.

In attendance were:

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. W. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. J. E. Howes, Research Staff, Bank of Canada;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics.

The Chairman submitted a letter from Miss Charlotte Whitton and one from Dr. T. C. Routley, General Secretary, Canadian Medical Association. It was agreed that these letters be printed in the evidence.

A brief from the Canadian Congress of Labour and also one from the Canadian Association of Social Workers, were, on motion of Hon. Mr. Bruce, ordered to be printed as Appendix "A" and Appendix "B", respectively, to this day's evidence.

After discussion it was decided to deal with the supplementary brief submitted by the Christian Science Organization which was printed in the evidence No. 6, of April 20, 1944.

Mr. J. W. Fulton was called and examined in connection therewith.

The following witnesses were also called and examined:—

Dr. J. J. Heagerty,

Mr. W. G. Gunn,

Mr. A. D. Watson.

Mr. Slaght moved:—

"That Mr. Gunn, in collaboration with the Advisory Committee, draft a clause which would clearly set forth the right of the Lieutenant Governor in Council by Order in Council to provide that, notwithstanding the Health Insurance Commission referred to in Section 19 (1) of the draft Health Insurance Bill, persons desiring not to accept the benefits conferred by the said Bill might be protected against compulsory acceptance of same; and also to

provide that payment might be made from the funds under the Act for such special and technical procedures and ancillary services as might be rendered to persons desiring same in lieu of regular medical services as to the Lieutenant Governor in Council might seem proper.

"That Section 10 subsection 3 of the draft Health Insurance Bill be amended by inserting after the word 'prescribed' in line three thereof the words 'by the Lieutenant Governor in Council'.

"That Section 2 (1) subsection (e) of the draft Health Insurance Bill be amended by adding after the word 'Commission' the words 'unless in this Act the Lieutenant Governor in Council is expressly authorized to prescribe'."

After discussion thereon further consideration was deferred until the next meeting.

On motion of Mr. Lockhart the Committee adjourned at 1.05 o'clock, p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

April 26, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Gentlemen, I should like to place upon the record two letters with your permission, one being from Dr. Charlotte Whitton clarifying statements that were made in the committee and another from Dr. Routley, Secretary of the Canadian Medical Association, giving the latest statistics with regard to membership of doctors in the Canadian Medical Association. Is it your wish that these letters be placed upon the record?

(Agreed.)

236C Rideau Terrace, Ottawa, Ontario,

March 30, 1944

Hon. CYRUS MACMILLAN,
Chairman,
Committee on Social Security,
House of Commons,
Ottawa, Ont.

HON. AND DEAR SIR:

In the sitting of the committee of date March 30th, Dr. J. J. Heagerty, Director of Public Health Services, Department of Pensions and National Health, is reported as casting doubt upon certain statistics in my "Memo for Canada", being section I of my report "The Dawn of Ampler Life", prepared under retainer of Mr. John Bracken.

The immediate point queried is my figure of \$3,142 as the average income for medical practitioners in Canada, which Dr. Heagerty is reported as stating to be in error. It is found on page 482, chapter VII, and again on page 483, table 17 of the report of the committee, chaired by Dr. Heagerty and bearing his name. On page 482 this figure is used as net average income, and quoted with the comparable net of the dentist at \$2,032, and the nurse at \$1,009. The figure of \$5,237 which Dr. Heagerty is now reported as offering instead is the gross average income, before allowable deductions, many of which cover items not chargeable under the Heagerty or any comparable publicly financed scheme of health service and care.

I would ask for the privilege of correction of the implications of Dr. Heagerty's reference in the next sitting and the next report of the proceedings of the committee, to which Dr. Heagerty as a civil servant can make statements, with which I, as a private citizen, can only deal thus indirectly.

Because of the wide publicity given to Dr. Heagerty's aspersion, I am giving a copy of this letter to the press.

Bespeaking your usual courteous consideration of what I deem to be but a reasonable request, I remain,

Yours sincerely,

(Sgd.) CHARLOTTE WHITTON.

CANADIAN MEDICAL ASSOCIATION

184 College Street, Toronto 2B,
April 24, 1944.

The Honourable Cyrus MACMILLAN,
Chairman, Committee on Social Security,
Ottawa, Canada.

Dear Doctor MACMILLAN:

It is evident from the printed proceedings of the meetings of the Committee on Social Security that the committee desires to be correctly informed with regard to membership in the Canadian Medical Association. With that end in view, may I present to you for the record the following information:

Total medical registration in Canada	12,235
Doctors living in retirement	615
Active	11,620
In military service	3,579
Active in civil life.....	8,041
C.M.A. members (not including those in military service) ..	5,597
Which is 69.6% of total number of doctors active in civil life.	

Including 3,579 members in military service our grand total of 9,176 members represents 80 per cent of Canada's total active medical population.

Yours sincerely,

(Sgd.) T. C. ROUTLEY,
General Secretary.

There is also a brief from the Canadian Congress of Labour, a copy of which is in your hands. Is it your desire that this brief should be placed on the record as an appendix?

(Brief appears as Appendix "A" to this report.)

There is also a brief from the Canadian Association of Social Workers. It is not a long brief. With your permission I shall place it upon the record.

(Agreed.)

(Brief appears as Appendix "B" to this report.)

At the last meeting we placed on the record a brief submitted by the Christian Science Association. It is contained in the printed proceedings which have been distributed. With regard to the brief submitted by the Christian Science Association, in the opinion of the chair this is a matter for consideration by the provinces, and in the opinion of the chair it should be referred to the provinces. Do you wish to discuss this matter?

Mr. BRUCE: I think we should discuss it here first and conclude consideration of this presentation that has been submitted to us, and whatever decisions are reached will be passed on to the provinces, just as we are doing with everything else.

The CHAIRMAN: What is the wish of the committee?

Mr. SLAGHT: We should discuss it here. There was an undertaking given by the chair last meeting that this matter would be the subject of discussion at this sitting.

The CHAIRMAN: It is at the present moment.

Mr. SLAGHT: I thought you were asking for an expression of opinion from the members of the committee as to whether this matter should be passed along somewhere else or discussed here.

The CHAIRMAN: Do you wish to discuss this matter before it is passed on to the provinces?

Mr. SLAGHT: Yes, very briefly.

The CHAIRMAN: There may be certain questions which certain members might want to ask Dr. Fulton who is here, and he will be able to answer those questions.

Mr. DONNELLY: They would be questions to elicit information from Dr. Fulton.

The CHAIRMAN: My point is, should we ask for information on a subject that seems to be under the jurisdiction of the provinces?

Mr. DONNELLY: This matter is under the jurisdiction of the provinces, and always has been; but as far as I can see there is no harm in hearing Dr. Fulton and getting any information he has to give.

The CHAIRMAN: The sense of the committee, as I interpret it, is that we should discuss this brief by way of questions—very briefly, as Mr. Slaght suggests.

(Agreed.)

Mr. BRUCE: Mr. Chairman, I did not have the privilege of being present at the meeting on June 1, 1943, when Mr. Fulton presented the case for the Christian Scientists of Canada, and only had the opportunity of reading this yesterday. In doing so I was struck by a few things which I think should be clarified. On page 454 of the evidence of June 1, 1943, Mr. Hansell, who appeared before the committee not as a member but because a member of his group was not able to be present, had this to say:—

Now, what I would like to ask the witness is this: I have some little knowledge of the philosophy of Christian Science; perhaps just enough to make my mind completely confused. . . .

I think that is the position of a great many people and, in particular, lay members of this committee. I fancy that the medical members are not particularly confused in regard to the question of Christian Science healing. I wish to refer later on to something which Mr. Hansell said. Perhaps I may as well do so now. On page 455 Mr. Hansell refers to the case of a child suffering from diphtheria who received treatment from a Christian Science practitioner, and the child died, and he added: "Of course, I know the argument to that is that the child might have died anyway, but the result of the case is this, that the woman was evidently advised she should not call a doctor. She took the advice and did not call a doctor. The result was that the child died. The woman realizing that the child's life might have been saved had she called a doctor was eventually taken to an insane asylum." Now, the gentleman who was giving evidence for the Christian Scientists on that occasion Mr. Eckman when asked a question replied as follows in this regard:—

A child does not lend its co-operation to anybody. It does not lend its co-operation to a Christian Science practitioner, as you say, and neither does it lend its co-operation to the doctor. The case is determined by the parents. They ask the doctor to come. He administers the

chemicals, or otherwise, to that child. In the Christian Science case the parents get in touch with a Christian Science practitioner and the practitioner provides the form of treatment of which they are capable. The cases are identical.

And then he goes on to speak with reference to a case he had mentioned previously about a child who walked with head and shoulders away back, and so on, which had nothing whatever to do with this particular case. But it really is characteristic of these men who profess this kind of faith healing to wander around in a circle, and I think I will be able to indicate that as I go along. There is no answer to the question that Mr. Hansell asked. If the child had had medical treatment and the appropriate specific anti-diphtheric serum, that child would probably have recovered.

Mr. WOOD: I notice you say "probably".

Mr. BRUCE: I say "probably" because it would depend upon the time at which the doctor had been called. If he had been called in the early stages of the infection in the throat there would be no doubt about the recovery of the child, but if he had been called in after the child had a membrane extending down into the larynx and the child was choking, why it would be too late then for any human aid, and for any divine aid, I am afraid, such as this.

Now I wish to refer to what the Christian Scientists are asking of this committee. You will see it on page 169 of the proceedings of the committee dated April 20, 1944. I should like to read some of the statements here because they are very interesting and perhaps revealing: "As an enjoyment or exercise of religious freedom . . ." Now, the part to which I wish to refer is to be found lower down in which they say—"it shall be the right of any qualified person on behalf of himself and his children and of any adult dependent, when so certified, to submit his or their complaints to medical diagnosis, and should illness be so established to receive treatments in accordance with the established practice of the Christian Science church by a Journal gazetted practitioner of that church," whatever that means, "whom he may choose . . ." ". . . in substitution for medical treatment as herein provided . . ." and so on.

My point is this, gentlemen, if you will think back a moment to the case I referred to, and assume that a doctor is called in, who diagnoses the child as having diphtheria—as it had—as the mother and the father are Christian Scientists—the doctor is then asked to turn the case over to the Christian Science healer and when his responsibility, according to this, ceases. I maintain that the doctor's responsibility does not cease if he knows that the patient has a disease for which there is a specific remedy which will cure that disease and that if that remedy is not used he knows the patient will die: I submit that the medical man, who turns such a patient over to a Christian Scientist, is guilty of criminal negligence and is *particeps criminis*. That is the position, gentlemen.

Mr. LOCKHART: Is he obliged by law to report all cases at once?

Mr. BRUCE: The doctor, yes.

Mr. SLAGHT: Under our law there is provision to punish for failure to secure medical advice where such action would have saved life. That is why I doubt Mr. Hansell's case very much—unfortunately, he is not present—unless you can show there was some investigation and that that was followed up. He says he was advised; it is a hearsay story.

Mr. BRUCE: Do I understand that you doubt his case?

Mr. SLAGHT: Yes, I will show you why in the language in which he puts it. The criminal law makes provision for such cases as Mr. Hansell cites. The person who advised against a doctor could have been prosecuted.

Mr. BRUCE: Mr. Chairman, I intended to take up that feature of the matter and I will do so in a few minutes, and perhaps Mr. Slaght will reserve his criticism until I have made the point clear.

Mr. McIVOR: Are we discussing the whole question of Christian Science or are we discussing this amendment?

The CHAIRMAN: We are discussing the whole brief. Before you proceed, may the chair point this out: if you will look at appendix A on page 155, at the beginning of the brief, it says that Christian Scientists ask for protection against the possible compulsory acceptance of Article III under the National Health Act and also that Christian Scientist treatments be accepted as a benefit for Christian Scientists under the Act; and in the letter received from Dr. Fulton he makes two requests: (1) to exempt them from the compulsory acceptance of medical or surgical ministrations or treatments under the Act; and (2) to provide that after medical diagnosis has determined the need of treatment and the approximate cost duly accredited Christian Scientists may have the necessary Christian Science treatment paid for from the fund to which they have made their contribution, that Christian Science treatment be a benefit under the Act after medical diagnosis.

The chair would like to suggest that we cannot discuss the relative merits of the treatment given by Christian Science practitioners as compared with medical practitioners any more than we can discuss the relative merits of one doctor's treatment with the treatment of another doctor. Secondly, I suggest that any question such as was brought up by Dr. Bruce just now should be discussed in camera when the bill is under consideration in camera. I do not think we should give publicity to certain ideas that we may have.

Mr. DONNELLY: My opinion, Mr. Chairman, is that this is a matter entirely for the provinces.

The CHAIRMAN: I have tried to point that out.

Mr. DONNELLY: Some provinces give a licence to Christian Science healers at the present time, I understand, and some do not, and it is entirely a matter for the provinces. This whole program is a matter for the provinces as it comes within their responsibility to care for the health of the people. We are only going to make a donation to assist them in carrying out their responsibilities, and we cannot dictate to them and say that they have to do this or that. The provinces are going to decide in the last analysis whether they are going to give licences to Christian Scientists to practise or not, and the same applies to chiropractors and drugless healers and so on. I think we are losing time.

Mr. WRIGHT: I find myself in agreement with the chairman. This is a matter which comes entirely under the jurisdiction of the provinces, and I feel that we are wasting our time in discussing the matter because it will have to be gone over again in each parliament.

Hon. Mr. MACKENZIE: I agree with Mr. Wright. I remember that when we had the unemployment insurance bill under consideration we heard all the evidence which was material first of all and then we closed the doors and as a committee we thrashed out the contentious features of the bill and reported it to the house. I think that is the proper way to make progress if there is any further evidence regarding the Christian Scientists; but I do not think we should go into the merits or demerits of the matter here because if we do we will never get ahead with the bill. It is a jurisdictional matter no matter what our opinions may be, and I think we would do well to go ahead with the work assigned to us.

Mr. JOHNSTON: I think we should deal with the two clauses indicated by the chairman; I believe that Dr. Bruce has dealt with something that is debatable and may lead to confusion.

The CHAIRMAN: We should do that in camera, otherwise it is bound to precipitate a discussion.

Mr. DONNELLY: I do not think we can decide this matter one way or another.

Mr. McIVOR: I spoke about this because I want to be fair, and I happened to be at the meeting when this matter was brought up before and I thought there was a fine statement made on both sides of the question. I do not see why we should go all through this again. This is an outstanding case, but it is not a general case with regard to Christian Science practitioners.

Mr. WOOD: Mr. Donnelly was correct in what he said in as far as the administration by the provinces is concerned, but it seems to me that we are setting out certain conditions here as a federal scheme with which the provinces must comply, and it seems to me that in all fairness to the people who enjoy certain religious convictions there should be something included in the Act which would give the provinces this premises: that the people who enjoy certain religious convictions will have those religious convictions protected. We are the government of the whole of Canada; we are even the government of the provinces. I am not a legal authority and I do not know how this is done, but I have certain religious convictions of my own, and one is that there should be, as far as possible, a divorce between the state and religion. I think that religion has found its greatest expression when the state has given it absolute liberty and has not tied it up to the state in any way. I think that is really all that Christian Science philosophy, as I might call it, has asked for. Now, Mr. Chairman, I do not know how this should be done, but if we leave it to the provinces one province is going to grant exemption of one type and another province may grant exemption of another type.

Mr. DONNELLY: You have that now. Some provinces give a licence to drugless healing and some do not.

Mr. WOOD: That does not take into consideration spiritual values. After all, there are spiritual values in life. I do not think we can afford to ignore them.

Mr. DONNELLY: The provinces are responsible for the health of their people and we are only offering them assistance. It really had nothing to do with the matter at all.

Mr. WOOD: Concealed in these conditions we set out certain other conditions. Therefore, I am almost prepared to say that the spiritual values of life contribute as much to happiness and health as even the material or medical. I do not think we should overlook the possibility of maintaining spiritual values.

The CHAIRMAN: I should like to suggest, if you will permit me, that Dr. Fulton is available this morning and we can ask him to address the committee very briefly and clearly regarding his objections to the bill and what he wants in particular, and we can discuss in camera his objections.

Mr. LOCKHART: In that event, should the osteopathic people want to have some witnesses come before this committee would that be permissible?

The CHAIRMAN: I think so.

Mr. LOCKHART: I am informed that they could make further representations. They thought they had made a full presentation before. Now, if we open this matter up, is it understood that they will have an opportunity of submitting further data or briefs in connection with the deliberations of this committee? I want that point cleared up.

The CHAIRMAN: If any member of the committee desires further clarification we could decide that in camera and call witnesses.

Mr. LOCKHART: It is not a question of any member of the committee calling witnesses, it is a question of whether the principle is to be adopted that we hear this evidence and refuse any other group.

The CHAIRMAN: We are not adopting any principle. I have pointed out that Dr. Fulton is here. If any member of the committee wishes to ask him a question he is here to answer it.

Mr. LOCKHART: If the committee accepts that principle that is all right; but I want it clearly understood that other groups may come and make oral representations if the committee so decides, and the committee will discuss each case on its own merits.

Mr. SLAGHT: Mr. Chairman, may I say a word before Mr. Fulton is called. The suggestion has been made that we have no concern with this matter because it is entirely under provincial jurisdiction. With great respect I say that is an entire misconception. Six provinces have recognized Christian Science already; British Columbia and Ontario have given them complete exemption from provisions which they asked for originally here. Mr. Fulton appeared last year and gave some evidence and the Christian Scientists have now filed a brief. Probably some of the members have not had time to read it. Their position as stated last year has altered. They then asked to be completely exempt from the taxation under this federal bill, but after conferences with Dr. Heagerty—I think he will confirm this—and perhaps with some other officers of the department—representations were made to them that that would be very awkward and they were asked to modify their request, which they have done, although not pleased with the modification.

Those of you who have their brief will find that a draft provision was made which is very different from an exemption and it is on page 11 of the brief they filed some two or three weeks ago and sent around to members of the committee. So we shall not be putting our minds needlessly to the question of exemption entirely, may I read briefly what their more modified proposal is. This was submitted, I believe, to the Department of Justice and I think it safeguards some of the matters that the committee were concerned about if a general exemption were to be granted. This you will visualize as a clause to be put in the bill:

As an enjoyment or exercise of religious freedom, it is provided that nothing in this Act shall be deemed and no regulations shall be authorized to compel any qualified person and/or some or all of his children and others dependent upon him from whom application for exemption is made (accompanied by a certificate of his and/or their membership in or adherence to the Christian Science Church signed by the provincial Christian Science Committee on Publication for the province of residence) to accept or to submit to physical, medical, or surgical ministrations or treatment contrary to his or their religious convictions, and it shall be the right of any qualified person on behalf of himself and his children and of any adult dependent, when so certified, to submit his or their complaints to medical diagnosis and should illness be so established to receive treatment in accordance with the established practice of the Christian Science Church by a Journal gazetted practitioner of that church, whom he may choose, in substitution for medical treatment as herein provided and the practitioner shall be paid on a rate corresponding to that of a medical practitioner hereunder in like case; but not so as to affect his obligation to observe laws and regulations respecting sanitation, infectious and communicable diseases, and quarantine.

The net result of that would be that a person desiring to secure Christian Science treatment would first have to submit himself to a medical practitioner. My view is that they are very foolish to concede that. I think they should be

exempt for reasons I will not burden you with now. That seems to be an eminently fair suggestion, and it will not be for us to suggest that their inclusion or their protection by something of that kind in this bill is a matter purely for the provinces. We are dealing with proposed federal legislation, and we have to face that. This measure will have to be passed upon like all our other measures and it will have to be dealt with by the provinces as well, and I suggest that we might well consider including their recommendation which would work out along the lines of that lesser recognition. It is all very well to scoff at Christian Science healing; I am not a Christian Scientist, but there is plenty of scriptural authority for the promotion of this type of healing and test. Those of you who are familiar with Christian teaching will recall the Epistle of James, chapter V, verses 14 to 16:

14. Is any sick among you? Let him call for the elders of the church and let them pray over him, anointing him with oil in the name of the Lord.

15. And the prayer of faith shall save the sick and the Lord shall raise him up; if he have committed sins they shall be forgiven him.

16. Confess your faults, one to another and pray one for another that he may be healed. The effectual fervent prayer of a righteous man availeth much.

Mr. LOCKHART: What year is that?

Mr. SLAGHT: I do not know. I am quoting Scripture. We do not laugh at Christianity nor at Christian principles. My Baptist grandfather, when I was a boy, went into the creek in the meadow and there he baptized by complete immersion people being received into the Baptist Church. Will anybody laugh at that in this committee? More than that, we all adhere to various communions; we have our rituals, our holy communions where bread and wine are broken up in the most solemn form. Most of us adhere to that belief; the Anglicans do, of which church I am a member; we believe in the forgiveness of sins, the resurrection of the body. My friend will, of course, correct me if I am wrong in that. The eternal life. With those Christian beliefs let us not laugh the Christian Science healers out of the committee or out of court; they are entitled to be received. Now, I have a high regard for the medical profession. I pay a doctor by the year to keep me well—not just to cure me when I am sick—and that is a pretty good method to follow in medical practice. But I do bespeak for these people this clarifying protection so that we do not compel them to pay. As Dr. Heagerty put it, if a Christian Science believer was getting a salary of \$2,200 we would take \$74 from him and we would compel him to pay it in order that he might receive a treatment that he would not accept or take, and he would have to pay his Christian Science practitioner if he needed him, quite outside of the \$74 contribution. That is not democracy at all. I think there is room for tolerance in this matter; but if we are going to laugh it off and laugh off the other rituals that Christian people practice and believe in—

The CHAIRMAN: In fairness to the members of the committee, I do not think that any member of this committee desires to laugh anybody out of court. Everybody will be heard who cares to be heard.

Mr. SLAGHT: The gentleman was amusing himself at my expense.

Mr. LOCKHART: There was no question of amusement. I merely asked a question: when this brief was presented and what it covered. I am quite satisfied to set my reliability and my Christian adherence up against that of the hon. member. Now, Mr. Chairman, there was not any question—Mr. Slaght is putting a construction on this matter that was never intended, and I object to the remarks of the hon. member.

Mr. SLAGHT: Through a misunderstanding of mine let me withdraw entirely any aspersion that my friend was laughing at what I said when he interrupted me. I was not reading the brief of the Christian Scientists but I was reading from the Epistle of James in the Scripture, and I was interrupted with the question: What date was that?

Mr. LOCKHART: What year?

Mr. SLAGHT: Is that a serious question? He wants to know what year the Epistle of James was written. That was a question intended to throw scorn upon what I was saying.

Mr. DONNELLY: You say that six provinces license Christian Scientists and three apparently do not.

Mr. SLAGHT: They recognize Christian Science by legislation.

Mr. DONNELLY: Suppose we pass this bill with this clause in it will we force these other three provinces that do not recognize Christian Science at the present time to recognize it by passing this legislation?

Mr. SLAGHT: No, I do not think so. You simply say that in administering this bill, when you take \$74 away from a believer of Christian Science compulsorily in taxation that this bill gives him the right to go to a medical practitioner, to Dr. Donnelly say, and then to get a certificate from Dr. Donnelly that it is a disease which can be treated, and then he can call in his Christian Science practitioner. I see nothing wrong with that. What about the other six provinces? Are we to take a stand that their recognition of Christian Science is to be vetoed by this committee?

Mr. DONNELLY: No, not at all. I say that it is up to the provinces. I think when you say to the provinces: You have to accept this, these clauses; you have to come under the provision of this bill, you are forcing the provinces to recognize Christian Science. I may be wrong.

Mr. SLAGHT: Six provinces have recognized Christian Science. Do you not equally say to those six provinces: Your recognition of Christian Science means nothing; we are going to bar that.

Hon. Mr. MACKENZIE: No, there is no intention to veto any legislation of any province in the Dominion of Canada. There is provision in this bill which enables a province to exclude any of these they want to exclude under their own legislation, and we have no jurisdiction here to confer rights such as this or take any rights away from the provinces. It is entirely up to the provinces as long as they give substantial compliance to what is accepted by the Dominion of Canada. I think there is a complete error in regard to this whole matter.

Mr. HOWDEN: If this is a provincial matter, why worry about it; why not leave it on the shoulders of the provinces?

Hon. Mr. MACKENZIE: That is where it is.

Mr. MAYHEW: Dr. Fulton is here, and I am quite sure that if we take a little time to listen to him he will clear up many of the things that are in our minds. What we are getting ourselves excited about I do not know.

Dr. HEAGERTY: Gentlemen, I will tell you what transpired between Mr. Southam, Mr. Fulton and myself on this subject. Both of these gentlemen came to my office on two occasions when we went into the entire question in detail. I pointed out to them that I did not wish them to exempt themselves or that they should be exempted from the payment of a contribution because every person in the community should contribute to the welfare of the community, and particularly inasmuch as public health played a very important part in the plan we had formulated. They were agreeable to that; they did not oppose the payment of a contribution; but they wished that a clause should be placed in the bill exempting them from acceptance of benefits. I told them that I could not come to any conclusion with regard to that matter, but advised them that no person

was obliged to accept any of the benefits indicated in the bill; and in order to pursue the question to finality I said I would submit it to the Department of Justice. I asked the Department of Justice if they would advise placing a clause in the bill, the clause that was drawn up by Mr. Fulton and myself. After some discussion we received the reply that such a section was redundant. Since that time the Department of Justice has written me a letter saying if we wish to include such a clause we might do so. It is obvious, inasmuch as no-one is obliged to accept any of the benefits of this Act, that such a clause would have no significance. I have referred to it on different occasions. There is a clause in section 4 which says that the statutory provisions made by a province shall be "substantially in the terms aforesaid." That is substantially in the terms of the provincial bill. If a province wishes it may exempt the Christian Scientists from accepting benefits; it may not exempt them from making a contribution, because section 5 of the Provincial Bill specifically states that every adult in the province shall make a contribution of \$12. It is within the power of the provinces, if they so wish, to include a section or a clause to the effect that the Christian Scientists, or any other group, may be exempted from accepting benefits; but there is no point in our putting in a clause in the bill inasmuch as it would not have any effect whatsoever.

Mr. KINLEY: The point at issue between you and Mr. Fulton is whether the Christian Scientist healer would be paid from the fund for his services if a citizen decides to take his treatment.

Dr. HEAGERTY: The question arose—I referred to it previously—that were we to agree to pay the Christian Scientists for their services we would be obliged to pay members of all churches who had recourse to prayer as a treatment for their people.

Mr. KINLEY: That is a point.

Mr. JOHNSTON: There is no section in the bill itself which compels anybody, Christian Scientist or otherwise, to receive medical benefits to this bill; but that is not a point of contention, as I understand, because there is a clause quite definitely in the bill which states that everybody must pay \$12.

The CHAIRMAN: Or an unspecified amount.

Mr. JOHNSTON: Yes, quite true. The point is this, that in the case of Christian Scientists they were refused, as I understand—Dr. Heagerty will correct me if I am wrong—they were refused exemption from paying the \$12. Then they asked for some consideration for making them pay which I think is justified. Dr. Heagerty pointed out clearly, and in every case he emphasized the point, that they were not compelled to receive benefits. They do not want the benefits, as I understand.

Dr. HEAGERTY: They want some of the benefits; they are willing to accept certain benefits, such as diagnosis, obstetrics, and surgery. They want the privilege of choosing those benefits and adhering to them. Of course, one cannot, in legislation, make an exemption of that nature.

Mr. JOHNSTON: I understand that the only reason they would submit to a diagnosis is to be in agreement with the doctors. I do not think they even care whether there is a diagnosis made by a medical practitioner or not. Dr. Fuller will be able to explain that point when he comes on the stand.

Dr. HEAGERTY: I understand they accept surgery and many of the procedures of the doctors.

Mr. JOHNSTON: I cannot say whether they want to accept obstetrics or certain aspects of surgery. Dr. Fulton will be able to explain that. It seems to me we will have to recognize the rights of some of these others, and I know that this is going to lead us into an argument in the case of the chiropractors. They too have certain privileges and the osteopaths have certain privileges they should receive under this Act. I am in agreement with what was said by Mr. Slaght: we will have to give this consideration.

Mr. WRIGHT: The first of this bill, I think, definitely comes within the power of this committee. That has nothing to do with the provinces. That is our affairs. If this bill is passed, any of the provinces that come under this legislation must accept the statement of the \$12 fee. If that is the fee that is going to be set they must accept that in order to come under this Act. The provinces cannot say of their own volition: We will not pay \$12. The Act will definitely set it and they must pay. How they are going to pay it must be decided. Once we decide on the fee of \$12—I may be wrong—then the provinces will have to agree to that. How are they going to pay \$12 may be up to themselves; we may give them permission to pay half through general taxation and have a contribution from each individual of \$6. That may be decided by themselves if we so permit it; but we will have to decide that here.

The CHAIRMAN: We will hear Mr. Fulton.

JAMES W. FULTON, called.

The CHAIRMAN: Proceed, Mr. Fulton.

The WITNESS: Mr. Chairman and gentlemen, I appreciate the interest which your committee is taking in going at length into this discussion. If I might have a few minutes I could bring the facts out in order and perhaps may anticipate and answer a lot of questions.

Last June when our brief was presented we asked that the Christian Scientists be exempted from the compulsory acceptance of the benefits, and secondly that we accordingly be exempted from the payment of the contribution. In January it was the privilege of Mr. Southam and myself to interview Dr. Heagerty and Dr. Wodehouse. At that time they requested that we should not press—as Dr. Heagerty has said—the question of exemption from payment, stating that there were 2,000 manufacturers who might also ask to be exempted and that would drain the financial valve. We, therefore, agreed to pay for our contribution. We pressed at that point for the inclusion in the bill of a clause specifically exempting us from the compulsory acceptance of benefits. Dr. Heagerty agreed to that principle and said that he would submit the clause to the Department of Justice. Mr. Varcoe's reply was that the inclusion of such a clause would be redundant because there was no compulsion within the Act itself. That we can technically agree is a correct statement. I am dealing now with that one point of exemption from compulsory acceptance of benefits. In February, in an interview with Mr. Varcoe, the Deputy Minister of Justice, we pointed out that the repercussions of this Act were not limited to the Act itself, that there would be provincial legislation drawn up, and that the making of regulations be left as wide open as the horizon. Without taking up your time now, we quoted certain provisions in the Act and in the summary which would indicate that later on it might be difficult to determine any measure that was to state that it was not compulsory. Mr. Varcoe, in view of the wider approach to the subject, agreed that it was quite proper to include within the Act a clause specifically stating the fact that there would be no compulsion in the acceptance of medical benefits. We are agreeable to that clause specifically exempting Christian Scientists, or being broad enough to protect everybody. Mr. Varcoe did not want Christian Scientists specifically mentioned in the Act because that would lead to the assumption that other people were under compulsion; but he did agree to a clause which would grant general exemption from acceptance of compulsory benefits. Then he said that he would write the department, and I believe that is the letter to which Dr. Heagerty has referred. In other words, at one point in our discussion Dr. Heagerty agreed to the inclusion of such a clause, and the legal department, the Deputy Minister of Justice, has agreed to the inclusion of the clause. I believe that all the members here are, in spirit, in approval of the inclusion of such a clause, and all that remains is to write it into the bill.

Our second point was that the matter of Christian Science treatment be accepted as a benefit under the Act. In June we asked to be exempt both from the benefit and the payment; in January, when speaking with Dr. Heagerty and he asked us to come in on the payments of contributions, we then discussed the possibility of having Christian Science treatment accepted as a benefit under the Act, and Dr. Heagerty will undoubtedly recall the fact that we submitted to him a proposal that Christian Science be included as a benefit under the Act on the affidavit of the patient and the practitioner that treatment was needed and given. Dr. Heagerty felt that that was too loose and we, in spirit, agreed with him. Therefore, our next proposal was that we set up a yardstick whereby Christian Scientists could have the benefits of Christian Science treatment under the Act, and this yardstick would serve as a protection for any criticism against the government. If I may interject for a moment, may I say that if Christian Scientists were all in the upper economic brackets then it would be possible for them to pay their contribution to the government for medical services which they do not want, and pay a second time for the service which they do want. Unfortunately, in our group as in all other groups, we are not all in the upper economic bracket and so it might present a hardship upon those who cannot pay double for their health services. And it was with that purpose in mind that we made this proposal I am referring to, to Dr. Heagerty.

Our second proposal was that a medical diagnosis be secured by the patient to do two things, both for the benefit of the government, not ourselves—we deplore the mixing of these things: first, that if a medical diagnosis were secured nobody could say that treatment was given when it was not necessary, and second, if medical diagnosis were given that fixed relatively the cost of treatment, as under the Workmen's Compensation Act at present. At the present time accidents and misfortunes under that Act are classified and an average cost is set up. We are proposing the same thing for this health scheme. We say that when the doctor makes his diagnosis he establishes the fact treatment is necessary; second, he establishes the relative cost of the disease or the treatment. And so the government is protected. Nobody can say that treatment was not required; nobody can say that the costs were excessive. Those discussions were with Dr. Heagerty. I do not wish for a minute to say that he approved of them, but it was a matter of discussion; and the clauses we think finally would do it in spirit—and which are on the last page of the brief—were placed in the hands of Dr. Heagerty and also of the minister.

That covers in a general way our points to date. I wanted to leave this matter clearly stated with you, and, in fact, we will be happy to include it as an added phrase in the Act, in our clause. You do not have to be concerned about the children. In the Criminal Code, sections 141 and 242, if a parent fails to provide the necessities of health—and this has been interpreted in court as including medical attention—if anyone fails to provide medical attention then he is liable under the Act, if there is death or permanent impairment of the child, to a charge as severe as that of manslaughter.

I have represented the Christian Science organization in the province of Ontario for close on fifteen years, and I can tell you that there is not one case in the whole of the Dominion of Canada in twenty-five years in which there has been any action taken against a Christian Science parent for failure to protect his child. In addition to the Criminal Code you have your provincial children's protection acts and children's maintenance acts and children's negligence acts. So you have a very wide field of protecting children.

I would like to read, with your permission, the last phrase of the clause which we have submitted to this committee. This is to assure you that there will be no negligence in the matter of observing the quarantine regulation:

“ . . . but not so as to affect his obligation to observe laws and regulations

respecting sanitation, infectious and communicable diseases, and quarantine." And I am willing to add, "and any children's acts, provincial or federal." Now, that is not good legal phrasing, but that is the spirit. So you do not have to be afraid that we will not observe the children's acts.

By Mr. Bruce:

Q. May I ask a question of the witness. Would Mr. Fulton tell us how he can observe the regulations in connection with reporting infectious diseases if the healer is not capable of making a diagnosis?—A. We call in a doctor always.

Q. Oh— A. And we strictly—we issue instructions to all our practitioners and members that the requirements of quarantine regulations etc., must be strictly and meticulously observed.

Q. Suppose you are called to attend a patient, do you immediately call a doctor to make a diagnosis?—A. Not unless it is of a contagious nature.

Q. How are you able to make a diagnosis that it is of a contagious nature? For instance, take the case of a sore throat; how do you know whether it is diphtheria unless you diagnose?—A. We do not. If there is any infection we can have a medical diagnosis. That is the practice in my own home.

Q. In other words, if you were called in to treat a patient with a sore throat would you as a practitioner call in a medical man to make the diagnosis, or would you not continue to treat that case for a few days?—A. If it is just a minor thing it might be that I would continue for a day or two. If it was distressing I would assure myself. A Christian Scientist is instructed to lean over towards the observing of these quarantine regulations, and not just to wait to see if there is some surety about it. If there is the slightest suggestion that the condition is within the contagious group, by all means they are to have a diagnosis.

Q. I cannot see how a Christian Scientist practitioner who is unable to make a diagnosis of diphtheria can recognize that the case is serious enough to call in a doctor, unless the case is in a late stage.

Mr. SLAGHT: In nine homes out of ten when a child has a sore throat the parents do not call in anybody, a doctor or anybody else; the case is treated at home first, and it is only when the sore throat becomes alarming that even in homes where there are plentiful means to have a doctor that they call a doctor in. We know about sore throats in this country; nearly every family has one. A doctor is not called in for that. Why do you point a finger at this gentleman for getting into a case where there is a sore throat and then calling a doctor when he feels it is time to call a doctor?

The CHAIRMAN: This committee cannot discuss methods of treatment in open session. We ought to discuss those things in camera.

By Mr. Fauteux:

Q. Suppose I am working as a lumberman in a province in which Christian Science is accepted under the provincial legislature and I suffer from an accident, I want to know if your practitioner will be paid by the Workmen's Compensation department of that province if I avail myself of the services of your practitioner?—A. He is not in Ontario, but as was written into the record at the June 1 meeting, it is the practice in the state of California. It is written right into the law specifically mentioning Christian Science by name in the state of Wisconsin. It is not in the Ontario Workmen's Compensation Act—it is not in the Dominion of Canada.

The CHAIRMAN: Proceed, Mr. Fulton.

The WITNESS: The reason we want these two portions of our clause written into the Act I think I have made clear on the part of the exemptions from the acceptance of compulsory medical care.

The other point is on the matter of the benefits. The Act now specifically mentions the benefits, medical, surgical, etc., and such other ancillary services as may be prescribed. That means may be prescribed by the doctor. The doctor is not going to prescribe Christian Science treatment. Furthermore, those who are privileged to provide the services are limited to medical practitioners duly registered and so forth in the province. So you have within the Act specific limitations which name the nature of the benefits and those who can provide the benefits. Now if our right to have Christian Science treatment as a benefit is not included in the master bill—your bill—then it becomes a matter of controversy, perhaps within all of the provinces.

I listened this morning and tried to get the sense of this committee and I am willing to go this far: you do not have to put this down in the Act as something obligatory, but in order to make it possible for the provinces to rightly include this if they so desire—those who wish—then simply state within the Act the fact that if the provinces wish to make provision for Christian Science similar to the clause included, or wording of a similar nature, that will be acceptable. In other words, you do not make it obligatory upon any province to accept Christian Science as a benefit, but you simply inform them that if they wish so to do it will not be disapproved by the master or federal bill.

That pretty well completes my case, although I would like to point to the wording used by Dr. Heagerty this morning. It may not have been his intent, but it was to the effect that if a province wishes to exempt Christian Scientists from the acceptance of compulsory benefits they may be privileged so to do. That would mean, to my mind, that if you are not exempt in a province from the compulsory benefits, you will have to accept them. So I will conclude my remarks, Mr. Chairman, unless someone wishes to ask me any questions; and I thank you for the very helpful and thoughtful way in which you have listened.

By Mr. Bruce:

Q. May I ask one further question? There has been a good deal of confusion in the minds of the committee as to what constitutes a Christian Science treatment; perhaps Mr. Fulton will explain?—A. If the chairman wishes me to go on a debate on religious principles I shall be glad to, but I do not think that is the spirit of the meeting.

The CHAIRMAN: We are not discussing the methods of treatment here; we can do that in camera.

By Mr. Bruce:

Q. I thought we could get the witness' evidence here and discuss it afterwards. Is there any objection to him stating the case?—A. I can perhaps state the effect. Christian Science treatment has been recognized under the laws of the province of Ontario since 1923. There is no conflict between the Department of Health in the province of Ontario and Christian Science practitioners. Is not that a sufficient answer?

Q. Mr. Chairman, that does not answer my question at all; it is a question of what constitutes treatment. I understand that a Christian Science healer goes into a room, stands beside the patient, and is silent for a certain period. I am asking why—

Mr. JOHNSTON: Mr. Chairman, on a point of order, I think we are getting into something that is very debatable, because someone may come along and ask what a doctor does when he goes into a room, besides presenting his bill.

The CHAIRMAN: I am sure that no two doctors in this committee agree on methods of treatment.

Mr. BRUCE: We have heard a good deal about religious treatment and about observing the principles of Christianity and prayer. I just want to state that I believe in prayer, of course, and every Christian does; but I wonder whether the Christian Science healer is praying when he is giving the treatment? Does it consist of a prayer to the Almighty—

The CHAIRMAN: Gentlemen, I am going to rule this discussion out of order. We cannot go into a theological discussion.

Mr. MAYHEW: What you are asking is simply that the Christian Science practitioner take the place of the regular doctor when the case is diagnosed and the patient needs some attention, and that the patient will pay for that attention?

The WITNESS: That is right. I should amplify that. That would apply in 95 per cent of the cases. If a surgeon is called in for a broken bone or something of that nature, in order to protect the government against any duplication of costs the surgeon's bill alone shall be chargeable against the fund. The wording of our clause is that Christian Science treatment is in substitution for and it receives payment only when it is that.

The CHAIRMAN: I understand you to say that notwithstanding the laws that have been passed covering medical treatment, in twenty-five years there has not been a case of criminal negligence reported?

The WITNESS: Not against our organization in the Dominion of Canada.

Mr. BRUCE: Or in the United States?

The WITNESS: Well, now, that is taking in a lot of ground. It is something like the statement that you quoted; I have no assurance that that was a Christian Science case, because if it had been, and the facts were as quoted, then there has been gross negligence on the part of the law enforcement officials.

Mr. SLAGHT: In twenty-five years medical men have been prosecuted in this country for negligence.

The CHAIRMAN: Order. Thank you, Mr. Fulton.

Witness dismissed.

Mr. GUNN: Mr. Chairman, as this discussion seems to centre around a legal point, I might be permitted to make a few remarks. I have not had the benefit of seeing or reading the opinion of the Department of Justice, but I doubt very much if it can be interpreted as the last witness has indicated: that the Department of Justice is all in favour of the introduction of such a section or provision in the Act. I doubt very much if that is the case. I do not think the deputy minister would go that far. But he merely said, in my opinion, that if in the wisdom of this parliament it is desirable to do that—to introduce any kind of exemption—it is possible to do it; it is legally possible. For example, any stipulation at all could be introduced into this Act—any stipulations the compliance with which would be the condition upon which the province would be entitled to a grant. One can just use one's imagination to a great extent. For example, if this province decided to introduce a provision insisting that in a province following this plan that blue-eyed persons in the province be exempted from contribution that would be quite in order, or that illegitimate children be not taken care of, that would likewise be in order; but surely that is a matter of policy. As I visualize this Act, it is merely an attempt by the dominion to assist the provinces in introducing a reasonably good health scheme; and as Dr. Heagerty has pointed out, and as I have pointed out on previous occasions, so long as the plans proposed by the provinces are reasonably satisfactory or substantially the same as that put forward in the draft bill, that is all that the dominion will require: reasonable and satisfactory plans or substantially the same.

Mr. JOHNSTON: May I ask Mr. Gunn if he was present at the interview between the deputy minister and Mr. Fulton?

Mr. GUNN: No.

Mr. JOHNSTON: You were not at the meeting and had not read the report and yet you are trying to give the deputy minister's or the minister's interpretation.

Mr. GUNN: I say I do not believe that the interpretation given by the witness can be considered a proper one.

Mr. JOHNSTON: Yet you were not at the meeting and have not read over the report.

Mr. GUNN: I make that statement in view of the fact that I happen to be a lawyer myself and I happen to know what the Justice Department might think of a proposition like this.

Mr. SLAGHT: You are not a mind reader.

Mr. GUNN: No. I have given this subject some study.

Mr. KINLEY: Did not the witness say just about what this gentleman is saying now, that the deputy minister said it was a matter of policy.

Mr. SLAGHT: May I ask a question? You heard Mr. Fulton say that his organization would be content if the committee passed a law making it clear to each province, first, that all Christian Scientists must pay the \$12 as has been mentioned. And that is not all there is; for a \$2,200 a year Christian Scientist it is \$74. Now, they have acceded to pay that. Could you not draw a bill for us which would make it clear to the provinces that they might do this—not exempt them from paying—but in the case where the province has recognized Christian Science as in the province of Ontario, for instance, that they could make it possible, after first going to a medical man and then going to the Christian Science practitioner that instead of paying fees to a doctor which they should not have to pay, the fees would be paid to the practitioner who does the work? There is no unfairness about that. The medical man does not do the work, the practitioner does. This man has already paid his \$75. Could you draft something which would leave that optional to the province? That is all Mr. Fulton is asking for now.

Mr. GUNN: Mr. Chairman, in my opinion it is optional with the provinces now, but it does seem to me like asking a man in advance to stop beating his wife.

Mr. SLAGHT: Is it optional with the provinces now to do what I am suggesting; to permit the Christian Scientist who has paid to call in his own practitioner and pay that practitioner out of the fund? If you tell me that that is the present situation under the bill and can show me it is I shall be content. If you are right and if that is there, show us—show us that the province may do that now. It is not clear to me. Can we not have three or four lines making that clear if the committee thinks that is fair?

Mr. GUNN: In answer to that I say this: the \$12 contribution and the other contributions which may come from persons who are able to pay more, but particularly the \$12 contribution, is put forward as a means of ascertaining the total amount expected from the provinces, and there is no reason under this Act or any other Act that the provinces may pass, why they cannot put in a provision exempting this class or other classes of people; but at the same time they will have to find ways and means of supplying that deficit, that \$12 per head deficit in order to make up their proper contributions.

Mr. SLAGHT: I was not asking about exemptions. Assuming that they are not exempted. You told us the province may permit a Christian Science

practitioner who has rendered service to be paid out of the fund for that purpose. Now, is that clear? I do not find that it is clear. If it is clear, all right; if it is not clear, make it clear for the committee. That is fair solution.

Mr. GUNN: That comes to the substance of the scheme in my opinion, and if a province puts forward a plan that is substantially in accord with what the dominion people regard as being a satisfactory measure of health insurance that is all that matters.

Mr. SLAGHT: It is not all that matters. Can you answer the question I am putting. Can the province say to-day that a Christian Science practitioner who has rendered aid under these safeguards can be paid out of the fund just as a doctor would be paid if he had rendered that aid?

Mr. GUNN: The answer to that is that it is purely a provincial matter in my opinion.

Mr. SLAGHT: It is purely a provincial matter in your opinion? Do not let us shut the door by our silence to the provinces in not making it clear in their minds that they have that power. That is all these gentlemen ask. They are prepared to go and plead their case before the provinces. Don't send them a recommendation that will prohibit them from getting the right from the provinces.

Dr. HEAGERTY: Mr. Chairman, will you refer to section 10, page 15, "Benefits"—Mr. Watson has just called my attention to it—"ancillary services"? When Mr. Fulton discussed this subject with me I called his attention to those two words. They are broad. They may include any services that may be beneficial to the patient. "The benefits referred to in the last preceding subsection shall include such special and technical procedures and ancillary services as may be prescribed" It does not say prescribed by whom. It means prescribed by regulation. If the province regulates that a Christian Scientist shall be paid, that he shall provide a service or a benefit which shall be paid for, then it is within the power of the dominion to agree. If you will refer to section 7 on page 4—(Mr. Watson has played a more important part than anyone else in drawing up this bill and he will, perhaps, advise me)—you will read as follows:

Every agreement made under section 3 of this Act shall be based on a report by the Minister to the effect that the conditions specified in this Act for the making of the agreement have been complied with.

Every agreement made under this Act is subject to the approval of the Governor in Council. I do not think we need to worry very much about the question. In the last analysis, as was pointed out at the very beginning, it will have to be decided upon by the Lieutenant-Governor in Council of the province by agreement with the Governor in Council. I do not think we can settle this question here. I think sufficient provision has been made in a draft to cover the question.

Mr. SLAGHT: Let me refer again to section 10, subsection 3: "The benefits referred to in the last preceding subsection shall include such special and technical procedures and ancillary services as may be prescribed . . ." Some members have suggested it might be prescribed by a medical practitioner.

Dr. HEAGERTY: Prescribed means by regulation.

Mr. SLAGHT: Do you see any objection to using the words "by regulations"?

Dr. HEAGERTY: You will find the definition of the word "prescribed" on page 2—the second schedule, page 11: "'prescribed' means prescribed by regulation of the commission". The commission may decide that a Christian Scientist may treat a patient and provide what is an ancillary service. That is a matter for agreement with the Lieutenant-Governor in Council.

Mr. JOHNSTON: It will be the commission that will prescribe these regulations.

Dr. HEAGERTY: That is by regulation. "Prescribed" by the commission means prescribed by the Lieutenant-Governor in Council.

Mr. SLAGHT: The commission will be presided over by a doctor.

Mr. WATSON: Regulations will have to be approved by the Lieutenant-Governor in Council.

Mr. SLAGHT: Would there be any objection to saying, "as may be prescribed in 10-3 by regulation by the Lieutenant-Governor in Council"?

Mr. WATSON: All regulations have to be approved by the Lieutenant-Governor in Council.

Mr. SLAGHT: Dr. Heagerty has said that prescribed means by the commission.

Dr. HEAGERTY: Regulations must be approved. A regulation made by the commission is a regulation made by the Lieutenant-Governor in Council.

Mr. SLAGHT: Of course, the commission is presided over by a doctor and you have to get that permission first. Why not leave it to the provinces if you are going to say, "Lieutenant-Governor in Council", because that is the cabinet. Do you see any objection to that: prescribed by order in council by the Lieutenant-Governor in Council?

Mr. WATSON: On page 38, section 40, it says: "All regulations under this Act shall be without effect until approved by the Lieutenant-Governor in Council . . ."

Mr. SLAGHT: That is not my point. You have to get the regulation first from the commission over which a doctor presides before you can go to the Lieutenant-Governor. Let us short-circuit that. The prescribing is done by the commission, and after the commission do the prescribing you have still to go and get that sanctified by an order in council from the Lieutenant-Governor in Council. I suggest we short-circuit the commission and let the province through its cabinet say what are the ancillary services that may be paid for.

The CHAIRMAN: You are making a distinction between prescribing and approving.

Mr. JOHNSTON: If the commission refuses to make such a regulation what would you do?

Mr. SLAGHT: You cannot get anywhere. Dr. Heagerty was good enough to take us to an interpretation on page 11 of the word prescribed, but under this bill as first drafted the commission is to be presided over by a doctor and until you get that prescribing done under 2 (e) you cannot get to the Lieutenant-Governor in Council at all. I suggest again that you are putting these people in the hands of a doctor in the province. If you want to give it to the province, qua province, the representative of the people, and with the voice of their cabinet, the right to see that these people may be paid, let us give it to the province and not interpose a commission headed by a medical man. I know the medical men will not think I have the slightest ill feeling because I have the highest regard for their integrity and their ability, but there is another principle involved in this legislation.

Mr. HOWDEN: May I ask Mr. Gunn if it is possible or if it would not be wise for us as a federal authority to sidestep this particular matter? Maybe I am wrong, but as I see it if we do insert in our federal bill a clause indicating that benefits will be paid to Christian Science practitioners then we are opening the door to pay benefits to all the irregular practitioners who practise in the field of medicine. If we do not have to assume this responsibility or this burden why do we do it? If it is a provincial matter why not leave it with the provinces?

The CHAIRMAN: We do not have to do it.

Mr. GUNN: I do not think there is any answer to that. I believe the last speaker is perfectly right; there does not seem to be any obligation on the part of the dominion to go into these matters which are partly religious and partly educational and partly metaphysical.

Mr. MAYBANK: Mr. Chairman, I think that probably we are not proceeding in the best way to undertake to make amendments to an Act. The point is whether or not we agree with the Christian Scientists in the proposal they have put forward. That proposal, as I understand it, is that they would just like to be sure that we do not tie the hands of the provinces with regard to their practitioners getting fees under certain circumstances. That, as I understand, is all they are asking at the present moment.

Mr. SLAGHT: Mr. Fulton says you are quite correct.

Mr. MAYBANK: Yes, I understand that is what they are asking. They do not want to find themselves in this position. They go to the province and they put forward a proposal, and that proposal is: "We are quite content to go to a medical man for a diagnosis; when we have done that we will go to a practitioner for treatment; the practitioner should be paid fees, and we ask you as a provincial body to arrange that in your law and have administration in conformity therewith. Under that set of circumstances we do not wish to be caught by the provinces passing the ball back and saying: "Now, you see, we are operating under a dominion law and the dominion law has really not left it open to us to make these arrangements." They just do not want to be caught in that position. That is all they are asking, and the first question before us is, do we wish to agree to allow that permission to the province so that a Christian Science practitioner or, perhaps, other irregular treatment specialists, as Dr. Howden says, will not be caught out in the provincial chamber.

That is the first point; and if the answer to that question be: Yes, we do agree with the Christian Science practitioner, then the second point is: does the law make that clear now? And if not, have it made clear. There is no question in my mind that a law can be drafted to make the point clear,—anything that we want by agreement in the provincial chamber.

Mr. GUNN: I agree that if it is not clear, that we are not interfering with provincial matters, and that we are not insisting that certain groups be not considered, then I say that a clause can be drafted to make it clear.

Mr. SLAGHT: That is fair.

Mr. MAYBANK: The point is whether we should do it.

The CHAIRMAN: I do not think we can answer that until Mr. Gunn draws up his clause and presents it to us.

Mr. SLAGHT: Mr. Gunn could draw up a clause along this line and submit it to us at our next meeting.

Mr. MAYBANK: I agree except that I think we ought to settle now whether we wish to have that left by freedom to the province or whether we do not.

Dr. HEAGERTY: The provinces have that freedom. I do not think we can give freedom to the provinces. It was stated that a doctor is the chairman of this commission, and the only criticism expressed by Mr. Slaght in regard to the implementation of this section is the fact that the chairman is a doctor. The chairman is only one man on the commission. This section has been drawn up in a very clear and specific manner, and we do not want to frame it in such a way that every individual under the sun who has some particular form of treatment shall be included. I may say this, that a great deal of time and thought and care and attention were given to the question of the inclusion of a clause to exempt the Christian Scientists. It was submitted to each member of the advisory committee in writing and each member of the advisory committee stated in writing that the Christian Scientists should not be exempted nor should

any other person be exempted whatsoever, and inasmuch as there is no compulsion on the Christian Scientists to accept a benefit no special privilege need be given to them. They have expressed themselves as being willing to make the contribution and also to accept those benefits that please them. They will accept diagnoses and such specific types of benefits—surgical benefits, obstetrical benefits as they wish; they want to stand back and fold their arms like a boy in front of a candy store window and say: we will accept that, and this—and you will pass legislation to that effect. That is unfortunate, because if we include them there is no doubt that the request is going to be greatly accelerated for opening the door to many persons who pretend to treat disease. There are a great many of them—irregular practitioners—and various types of healers. These men pretend to treat disease. They do not know the human body, they do not know disease; there are many doctors who are in a position to know that these men through ignorance have caused death, they have committed murder through ignorance. That is why Dr. Bruce has asked such specific questions of Mr. Fulton; he has the interest and the welfare of the public at heart.

Mr. SLAGHT: Do you suggest that the rest of us have not?

Dr. HEAGERTY: I would suggest that Dr. Bruce has a more intimate knowledge of these matters than has any layman at this meeting, and I suggest that the doctors who are here have special knowledge and information, and therefore are more intimately concerned. They see the person who is dead. A year ago I was called across the way to see a neighbour who was treated by an irregular practitioner—a woman suffering from cancer—who was given reducing treatments—the woman died.

Mr. MAYBANK: I rise to a point of order.

The CHAIRMAN: What is the point of order?

Mr. MAYBANK: Dr. Heagerty is addressing himself to a principle involved here, which is not the issue at the moment; we are discussing whether or not we should have a certain amendment made to the law merely as a draft; and in the second place, with all respect to Dr. Heagerty, I think he should not be engaged in any such discussion except when called upon as a witness. I regard it as rather unfortunate that there should be polemical discussion of this sort by the department's men. This is a parliamentary matter and is not to be settled by departmentalists asserting what will be done or what will not be done or what should be done, and so forth. I have the greatest respect for Dr. Heagerty, and I think he has done a great deal of work in the preparation of this bill, but I am a little afraid of his creating the impression in the minds of members of parliament that something is to be pushed down their throats. I would regret if any such impression became prevalent, and I fear it will become so because it was beginning to grow on me, and I, personally, am allergic to any such idea. What we have to have settled is whether or not we desire to leave the freedom with respect to the matter in question to the provinces. We have to decide whether the law does leave that freedom, and if it does, well, I suppose, we will be content; but we should not get heated up about chiropractors or Christian Scientists or herbalists or anybody else.

Mr. SLAGHT: I am going to make this clear—

The CHAIRMAN: Nobody is getting heated.

Mr. SLAGHT: It was Dr. Heagerty's statement that Dr. Bruce has proceeded having the public interest at heart, and the suggestion is that in glorifying him that the rest of us have not. I do not think Dr. Heagerty intended that. Mr. Maybank has put it this way: if you are going to leave the matter to the provinces the present bill interposes between the provinces—the governments of the provinces, speaking for the people—it interposes the necessity to go before

a commission headed by a doctor, and you cannot get to the provinces until you get past that commission. That is my point. Let us send it to the provinces. We are all agreed, I think, that the provinces should have the right in that respect, and we are not dragging in those awful people that Dr. Heagerty is afraid of. The province of Ontario has said: we recognize Christian Science; and I would like the cabinet of the province of Ontario to have the right to say that they prescribe a practitioner as someone who may be paid.

The CHAIRMAN: Mr. Slaght has made a motion, seconded by Mr. Fulford, requesting Mr. Gunn to draw up a clause that may be submitted to the committee.

Mr. SLAGHT: A clause that will make it clear that this committee desires to have the provinces as such deal with the question as to whether or not the practitioners—we do not need to name Christian Science at all—follow the language—such ancillary services as may be prescribed; and I think it would be an amendment by order in council in any province, and that does the whole job. And then strike out the definition of prescribed that is over here and ties it into a commission to do it.

Mr. GUNN: I have been scribbling out a very rough draft of a clause which I will put forward in a moment to see if I can get the sense of what the committee requires. This is a provision in a dominion bill: "No grant under this Act may be withheld or denied by the dominion by reason of the province in its statutory provisions, allowing for the exemption of persons from the contributions and benefits of any insurance plan proposed."

Mr. SLAGHT: That is good as far as it goes, but it still leaves the necessity to go to a commission headed by a doctor, unless you make it clear in 10-3 that ancillary services may be prescribed by order in council, and alter the definition of "prescribed," by the Lieutenant-Governor in Council. Do you see any objection on top of Mr. Gunn's amendment to putting the words after "prescribed," "by the Lieutenant-Governor in Council of a province"?

Mr. GUNN: I will have to give that some consideration. There is more involved, I think, than merely the matter of changing a word. I am not satisfied that the ancillary services do include all that has been suggested. They include, perhaps, things less important than fundamental rights of citizens to be relieved from duties and obligations. I will give that some further consideration.

The CHAIRMAN: This will come up under section 10 under "benefits".

Mr. JOHNSTON: The term "prescribed" will come under page 11.

The CHAIRMAN: Yes, but under ancillary services. There will be ample time to draw up this clause.

Mr. LOCKHART: I do not recall the number on the commission. It is quite a number I presume?

Dr. HEAGERTY: Section 19 will give you the number. There is only one doctor, and the public health officer ex officio.

Mr. WRIGHT: There is no stated number.

Mr. LOCKHART: Quite a number is anticipated. Now, may I ask this so that I can express my view intelligently. This suggestion would circumvent dealing with any matter before the commission, and with respect to the matter Mr. Slaght has raised it would circumvent the commission in this particular instance. I would like to ask Mr. Gunn if that would not mean that by an amendment to the bill we might prescribe other circumventions and get by the commission to the Lieutenant-Governor in Council?

Mr. GUNN: That is one of the dangers.

Mr. LOCKHART: The intention of what Mr. Slaght proposed is that they circumvent the commission on this one particular issue and leave the commission in full charge on all others. That is a dangerous thing.

Mr. JOHNSTON: I would not take it that the suggestion made by Mr. Slaght pertains to Christian Scientists; it may pertain to chiropractors and osteopaths.

Mr. SLAGHT: The province as such. Let the province decide this, and they could prescribe that osteopathic treatment was a special and technical procedure, an ancillary service, that is the language. Mr. Gunn may wonder whether that would be broad enough to cover it, it seems it would; but it is a question whether you want to leave it to the provinces or take it away from the provinces. Now you are taking it away from the provinces and giving the power of approbation to a commission, a number of men—how many is in the gift of the province—but their chairman must be a medical man. Now, that is the delegation of a very dangerous power if we are impressed with the fact that the Christian Scientists ought to have a right to make a case with the province.

Mr. WRIGHT: It seems to me that the committee is losing sight of one point, and that is that the provinces may adopt the commission form of management or they may leave it with the Department of Health within the province. If a province wishes to keep complete control it can do so under the bill. This bill does not force the provinces to adopt the commission form of management for their medical health scheme.

Mr. JOHNSTON: Where is that?

Dr. HEAGERTY: Section 4, page 3: “. . . as a satisfactory practical measure of health insurance for the province and the Governor in Council may approve of statutory provisions which are to be administered by a provincial department of health in lieu of a commission . . .”

Mr. SLAGHT: Then you have to amend one thing or the other, because section 19 says: This Act shall be administered by a commission to be appointed by the Lieutenant-Governor in each province, so that the two do not jibe. There is the word “shall” in section 19.

Mr. WATSON: The draft bill for the provinces to enact is really a suggestion to the provinces, and the provinces will decide whether they wish to retain administration by a commission or whether they will have some other sort of administration, and they will enact it in that form. I think the same thing is true with reference to the whole subject we have been discussing to-day. If a province wishes to specifically exempt Christian Scientists or any other class or have the Act apply to them in any special way in their own draft legislation—the provincial legislation they will put through—they will make specific provisions along those lines, if the provisions in the draft proposed by the dominion are not sufficient to meet their view.

Mr. LOCKHART: I presume that in this anticipated conference these matters will be discussed, will they not?

Dr. HEAGERTY: Mr. Slaght has placed a question before Mr. Gunn and has asked him to draw up a clause. Would you object, Mr. Slaght, if that question were placed before the advisory committee on health insurance so that we may discuss it? Mr. Gunn is one member of the committee.

Mr. SLAGHT: No. Of course, we would like the benefit of all your views on this. My own view—and I only speak for myself—is let us leave it to the provinces and not put a barrier in the way of it being dealt with by the cabinet by order in council. No matter how eminent a commission may be we do not know who they are nor how many there will be or anything else. If I am wrong in thinking that the committee believe it is a matter that should be left to each province, then you will disagree, but I think that a province, qua

province, should have the power to permit these people to be paid or not to be paid. So long as Mr. Gunn brings out something of that kind and the rest of us decide on the matter, that will be clear.

Mr. HOWDEN: Assuming that we do adopt this clause that is requested of us, is it not so that that is a specific instruction or demand on the provinces to adopt that legislation or raise an issue with the federal authority to clear the matter up?

Mr. SLAGHT: It does not do that at all; but I will go further and state that if we passed in the House of Commons a bill which deprived the provinces of exercising their discretion on the very point I think they should have the right to exercise it on, it would be ultra vires, and a court would set the dominion bill aside.

Mr. HOWDEN: What is the use of putting it in?

Mr. SLAGHT: It is ambiguous the way it is. It looks as though we have taken the power away from them. We have said: you must allow a commission to be appointed in some way who may do what you now have a right to do under the British North America Act; and that is a fault in this bill. My suggestion is that section 10-3 be amended; that the benefits referred to shall include such special and technical procedures and ancillary services as may be prescribed by the Lieutenant-Governor in Council in any individual province; and then to be consistent we will have to make some slight amendment to the definition of the word prescribed, and make it mean prescribed by regulation of the commission, unless otherwise in this Act it is to be prescribed by the Lieutenant-Governor in Council. Those two amendments will make it clear.

Dr. HEAGERTY: Does not that divide the responsibility as between the commission and the Lieutenant-Governor in Council?

Mr. SLAGHT: It does, but it is clear if you take those two amendments I have proposed, because 10-3 only deals with the benefits referred to in the last preceding subsection, and those benefits shall include such special services as by order in council any province may prescribe. When you come back to the word "prescribed" if you define it as now it says: "Prescribed means prescribed by regulation of the commission"; except where in this Act it is otherwise expressed provided it shall be prescribed by the Lieutenant-Governor in Council. That only deal with the matter of benefits under 10.

Dr. HEAGERTY: This section deals with every benefit that is provided and the manner in which benefits are provided. It must be within the power of the commission to state the manner in which the benefits are provided. It will be necessary to indicate how the doctor will be paid, whether he will be paid a salary, whether the nurses will be on a basis of salary, and what are the hours of work.

Mr. SLAGHT: Why do we purport, as a dominion government, to say to a province: we are going to take away from you the right by law under the Constitution that you have in these things, and we are going to tell you you have to delegate your authority and appoint a commission to do it instead of you being allowed to do it? I venture to say that if a province wanted to break this Act it could go to the courts and have it declared ultra vires, an invasion of the field of legislation solely within the province. As we are now, I think we are saying to the provinces: we are telling you federally that you cannot determine this matter of benefit, you have to appoint a commission and delegate power to a lot of unnamed men and a doctor must be the chairman, and you have to give away to them the right you now possess under the British North America Act. I would like to have Mr. Gunn say, as a lawyer, that that would be within the

right of the dominion parliament or whether it would not. I think he says it would not; it is an invasion. Do not let us send a silly bill forward which tells the provinces what they have to do, that they have to send these people to a commission instead of recognizing the rights they have. Mr. Gunn says now—

The CHAIRMAN: Mr. Gunn says he wants a little time.

Mr. WRIGHT: With regard to administration, I think there is a duplication—

The CHAIRMAN: We have to discuss the whole bill next time, and we will take up those matters.

The committee adjourned to meet at the call of the chair.

APPENDIX "A"

MEMORANDUM ON THE DRAFT BILL RESPECTING HEALTH INSURANCE, PUBLIC HEALTH, ETC. SUBMITTED TO THE SOCIAL SECURITY COMMITTEE OF THE HOUSE OF COMMONS, MARCH 31, 1944, BY THE CANADIAN CONGRESS OF LABOUR.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

The Canadian Congress of Labour, representing some 250,000 organized Canadian workers in a wide variety of industries, welcomes this opportunity of placing before you its views on the Draft Health Insurance Bill and the question of health services generally. The revised Draft Bill, in the opinion of the Congress, represents a marked improvement over the version presented to you last Session. None the less, there is still much room for further improvement.

1. *Finance:*

Any sound scheme must be based on the principle of ability to pay. The financing of this scheme is a flagrant violation of that principle. The flat rate contribution of \$12 per adult is simply a head tax, perhaps the most objectionable type of tax there is, and certainly one that has no relation at all to ability to pay. The flat percentage income tax of 3 per cent for single persons and 5 per cent for married persons is almost equally objectionable, especially in view of the maximum limit of \$30 for single persons and \$50 for married persons. Both forms of contribution would bear very heavily on those in the low income groups and hardly at all on the well to do. They would be particularly burdensome for those in the low income groups who have large families: precisely those to whom the Government, by its projected family allowance legislation, is proposing to make special grants, presumably because of special need.

The gross inequalities and injustices which would result from the proposed system of financing may be illustrated by a few specific examples:

TABLE 1

Type of Contributor	Contribution
Married man, income of \$500, 4 dependent children over 16.....	\$ 72
Married man, income of \$1,500, 4 dependent children over 16....	87
Married man, income of \$50,000, 4 dependent children over 16...	122
Married man, income of \$50,000, no dependent children over 16..	74

It will be noted that a married man with an income of \$500 and 4 dependent children over 16 years of age would pay only \$2 less than a married man with an income of \$50,000 and no dependent children over 16 years of age; also that a married man with an income of \$1,500 and 4 dependent children over 16 years of age would pay only \$35 less than a married man with an income of \$50,000 and 4 dependent children over 16 years of age.

Comparison of the payments by single persons and married persons without dependent children, within given income groups, also reveals marked inequalities:

TABLE 2

Income	Single person pays	Married person pays
\$1,200.....	\$28 20	\$24 00
1,300.....	31 20	29 00
1,400.....	34 20	34 00
1,500.....	37 20	39 00
1,600.....	40 20	44 00
1,660.....	42 00	47 00
1,700.....	42 00	49 00
1,800.....	42 00	54 00
1,900.....	42 00	59 00
2,000.....	42 00	64 00
2,100.....	42 00	69 00
2,200.....	42 00	74 00
Over \$2,200.....	42 00	74 00

In the first three cases, the single person pays more than the married, though by diminishing amounts; in the next three, the married person pays more than the single, by increasing amounts; in the rest, the single person's payment remains stationary, while the married person's increases by constant amounts per \$100 of income till the income reaches \$2,200, when the married person's payment also remains stationary. From \$1,200 to \$1,600, the single person's payment increases by \$3.00 per \$100 of income, while the married person's increases by \$5.00 per \$100 of income; from \$1,600 to \$1,660, the single person's payment increases by \$1.80, while the married person's increases by \$3.00; from \$1,700 to \$2,200, the single person's payment remains stationary, while the married person's increases by \$5.00 per \$100 of income; from \$2,200 up, both of payment remain stationary. The Congress is unable to understand what principle of equity dictated these schedules.

It is true that the Draft Bill provides that when anyone can prove inability to pay part or all of his contribution, his payment would be reduced by such amount as the Provincial Health Insurance Commission determined, and the Provincial Treasury would make up the difference. But while this might give some relief to the poorest contributors (a relief which might vary from province to province with the strictness or otherwise of the Commissions concerned), it would do nothing at all to correct the inequalities and injustices as between other contributors, and it might involve some provinces in very serious financial difficulties. Some provinces with a large proportion of their people in low income groups, might have to shoulder very considerable burdens from the very outset. Other provinces are largely dependent on particular crops or particular industries. Failure of such crops, or a catastrophic decline in prices, or severe unemployment in the industries concerned, might mean that large numbers of contributors would be wholly unable to meet their payments, which would then fall back on the province, that is, on the provincial taxpayers generally. The capacity of such taxpayers to meet the added burden would, from the very fact of the crop failures, decline in prices, or severe unemployment in the basic industries of the province, be drastically reduced; and the effort to keep up the health insurance payments might mean starving other equally necessary social services, or even in some cases actually reducing the taxpayer's income to a point where he and his family would go short of proper food, clothing and other necessities of life. Furthermore, it scarcely needs saying that the financial capacity of the various provinces differs very markedly, and that a sum which could be easily met by one province might impose an intolerable strain on another. That one province might be labouring under such a strain while another was carrying on comfortably and even prosperously would hardly tend to promote national unity. If one province was obliged to reduce its health services, or reduce its other social services in order to maintain its health services, while other provinces were maintaining theirs, the effect on national unity would be even worse.

The Congress believes that the only equitable method of financing health insurance or health services is by taxation based on ability to pay. The whole cost should be met out of the proceeds of steeply graduated income and inheritance taxes levied by the Dominion. Any other system is bound to be unfair as between different classes of contributors, and bound also to penalize the poorer provinces and delay their adoption of the scheme.

This last is a very serious objection to the present proposals. One of the prime objects of any health insurance scheme worthy of the name is to make its benefits available as promptly and fully as possible to every citizen of Canada, no matter where he lives: Prince Edward Island or British Columbia, Manitoba or New Brunswick, Quebec or Ontario or Saskatchewan. If the provinces are called on to bear any appreciable part of the burden, the result will simply be that the richer provinces will come in and the poorer ones will stay out, their sense of injustice increased by the fact that through their Dominion taxes they will be contributing to provide for their more fortunate brethren services which

they cannot get for themselves. That the delays involved may be prolonged is clear from the fact that in the case of old age pensions, where the total cost is even now only about one-sixth of the estimated cost of health insurance, one of the two chief industrial provinces did not come in till nine years after the inception of the scheme, and both Quebec and the Maritime Provinces came in only after the Dominion had assumed three-quarters of the cost.

It may be added that when the war ends one of the chief requirements for the readjustment of the national economy will be mobility of labour as between different parts of the country. It is in the highest degree undesirable that labour should be frozen in certain areas when it might be more effectively employed elsewhere. But a scheme under which some provinces provided health services of the kind contemplated by the Draft Bill, while others did not, would have precisely this undesirable effect of freezing labour in the areas which had health services, even though it might be to the advantage of the nation as a whole that they should move elsewhere.

The Congress also feels obliged to protest against the proposal to have employee's contributions deducted by the employers from their pay envelopes. Workers feel that they already have more than enough of such deductions; to add another, especially one so inequitable as that proposed in the Draft Bill, could hardly fail to be a constant source of irritation and a cause of industrial unrest.

It has been contended that health services financed out of taxation might "encourage the pauper mentality and create a delusion that the public purse is bottomless, thereby encouraging extravagance and maladministration"; that "it is more consistent with the dignity and independence of man that he should purchase the necessities of life with his own money"; that "under a contributory system, benefit becomes a right and not a charity"; that "beneficiaries who are contributors feel a sense of responsibility in regard to the cost of services and administrative procedures". The only comment the Congress feels it necessary to make on these contentions is that their authors appear to have overlooked the existence of a large number of school systems financed out of taxation, both in Canada and abroad. The Congress is not aware that this fact has "encouraged the pauper mentality", "created a delusion that the public purse is bottomless", "encouraged extravagance and maladministration", or undermined the "dignity and independence of man." It is under the impression that the public is purchasing educational services with its own money, that such services are "a right and not a charity", and that the taxpayers who support the schools "feel a sense of responsibility in regard to the cost of services and administrative procedures". Indeed, a criticism often heard is that they feel too great a sense of responsibility in regard to the cost of services, and that the schools are starved of the necessary funds.

The prospect of paying for anything, health services or anything else, out of taxation, is not an agreeable one, especially at this time of year! But if we want adequate health services, we must be prepared to pay for them. We are already paying, heavily and very inequitably, for inadequate services, not only directly but also through the immense loss in productivity resulting from needless illness. We should also be paying, heavily and inequitably, under the system of financing proposed in the Draft Bill. With full employment, with our energies and resources directed (as they should be, once the war is over) to the maximum production of goods and services to meet the people's needs, and with the increased productivity which better health would make possible, the total real cost of adequate health services will be less than the cost of present inadequate services. With that cost met out of taxation based on ability to pay, the burden, such as it would be, would rest where it ought to rest: on the shoulders best able to bear it.

2. Administration:

The administration of health insurance under the scheme proposed in the Draft Bill leaves a great deal to be desired. In the first place, it is heavily weighted in favour of the doctors and others providing the services; the representation accorded to the general public, those who would consume the services and, it may be added, pay for them, is altogether inadequate. In the second place, the administration proposed would appear to make no sufficient provision for that integration of preventive and curvative work which is essential if any health insurance scheme is to produce its full results.

The actual administration of the scheme will be mainly in the hands of a Health Insurance Commission in each province. This Commission will have a minimum membership of fifteen. Of these, three will be doctors; the Chairman (who will be the Chief Administrative Officer), the provincial Deputy Minister of Health or the Provincial Health Officer, and at least one other member appointed "after consultation with organizations representative of medical practitioners". Four more will be representatives of other professions or institutions supplying the services, appointed "after consultation with organizations representative of dental practitioners, pharmacists, hospitals and nurses". Two will be appointed on the nomination of the Dominion Government. Only six of the fifteen will be specifically representative of the public who pay for the services. One of these will be appointed after consultation with organizations representative of the insured persons, that is, the whole population of the province; exactly what organization will be consulted, or how the provincial Government will choose among the variety of candidates likely to be presented to it, remains to be seen. The other five consumer representatives will be appointed to represent industrial workers, employers, agriculturists, rural women and urban women respectively, after consultation with the representative organizations in each case. In other words, the representatives of the consumers will be in a distinct minority on the Commission, for we cannot assume that the two representatives of the Dominion Government will necessarily be laymen, indeed the composition of the proposed National Council on Health Insurance, on which we comment below, suggests that they are much more likely to be representatives of the professions. Furthermore, it must be noted that the Commission need not meet more than twice a year, and that between meetings its powers will in effect be wielded by the Chief Administrative Officer, who must be a doctor; so that in practice the administration is likely to be even more completely professionally controlled than the composition of the Commission would suggest.

The Congress believes that on any Commission set up to administer health insurance the representatives of the consumers of health services, the people who pay for the services, should have a clear majority; and it sees no reason for the requirement that the Chief Administrative Officer must be a doctor. On purely professional questions, the professions must of course have the deciding voice. No one in his senses would suggest that a group of laymen should decide whether John Smith should have his appendix out, or whether Joan Brown should be given this or that drug. But the economic and general aspects of administration are very definitely not matters on which the professions and other suppliers of services should have the deciding voice. On these the professions have no special competence. The people who foot the bill should have control. "The health services for the doctors", or the doctors plus the dentists plus the pharmacists plus the hospitals plus the nurses, is an unjustifiable, and indeed as dangerous, a slogan, as "The mines for the miners" or "The railways for the railwaymen". No group of human beings is good enough to be trusted with such power; there will always be a tendency towards group selfishness, accentuated by the fatal facility with which we all tend to identify the public interest with our own. It is the Commission which will make the financial arrangements with the professions and the hospitals; if the Commission is to

be predominantly professional, the process will be much too reminiscent of "collective bargaining" between an employer and a company union: the same people sitting on both sides of the table.

The composition of the National Council on Health Insurance is even more objectionable, though its duties are left so vague that it is impossible to say just how important it will turn out to be in practice. The size of the Council is left undetermined; but if all the provinces come in, it will consist of at least twenty-two members. Of these twelve will be doctors (the Dominion Director of Health Insurance, the nine Chief Administrative Officers of the provincial Commissions, and the representatives of public health officers and medical practitioners as such), and four others will be representatives of other supplies of the services (dentists, pharmacists, hospitals, nurses), while six will be representatives of the consumers (insured persons, industrial workers, employers, agriculturists, rural women and urban women). This representation of the consumers is ludicrously inadequate; and it may be added that there is nothing to ensure that the "representatives" of the consumer groups shall be really representative. The Section of the Provincial Draft Bill governing the appointment of the Provincial Commission provides that the representatives shall be appointed after consultation with the organizations concerned; but there is no such provision in regard to the appointments to the National Council.

The second main objection to the administrative features of the Draft Bill is that it makes no sufficient provision for the integration of preventive and curative work. In the past, the emphasis in the practice of medicine has been on cure. Everyone now agrees that in the future it must be on prevention. But it will be very difficult to secure this shift of emphasis unless preventive and curative services are thoroughly unified. The Draft Bill does not unify them. On the contrary, it explicitly provides for two sets of administrations, those of the "Health Insurance Regions", under the Health Insurance Commission, and those of the "Public Health Regions", under the public health authority of the province, "with such provision for co-operation between the administration aforesaid as may be deemed necessary and advisable in the interests of public health". The Congress believes that much more than this is required.

3. *Inadequacies of the Draft Bill.*

Apart from the specific criticisms already noted, the Draft Bill is seriously deficient in at least four important respects:

(a) It makes no provision for cash benefits to maintain minimum income during interruption of earning power on account of illness. It may be answered that this is outside the scope of the proposals under consideration, and that it would require an amendment to the British North America Act. The fact remains that the best of health services will not produce its full effects if, while the beneficiary is under treatment, he and his family are suffering a drastic reduction in their standard of living and he is constantly tormented by worry about where the next meal is coming from. If this question is outside the scope of these proposals, it is certainly not outside the scope of the people's needs, and some provision must be made for it, whether in this Bill or another. The constitutional difficulties can be overcome, either by generous grants-in-aid, or by a redefinition of "unemployment" to include unemployment resulting from illness, or by an amendment to the British North America Act similar to the Unemployment Insurance Amendment. The British North America Act was made for the people, not the people for the British North America Act. It must not be allowed to stand in the way of meeting the people's needs. No provincial right is undermined by payments from the Dominion Treasury to people who are unemployed because they are sick.

(b) The Draft Bill makes no provision for the extra medical, dental and nursing personnel who are even now urgently necessary, and who will be not

less but more necessary under a health insurance scheme. The American Committee on the Costs of Medical Care considered that there should be one doctor in every 700 of the population and one dentist to every 1,000. The recent Health Survey by the Canadian Medical Procurement and Assignment Board has shown that Canada falls very far short of this standard. Indeed, if this standard were accepted for Canada it is probably not far from the mark to say that Canada needs four or five thousand more doctors and three or four thousand more dentists; and even under the present accelerated system of medical training the annual average number of graduates from Canadian medical schools is only about 745. The Medical Procurement and Assignment Board itself adopted the much more modest standard of one doctor to every 1,500 of the population; even so its survey revealed an acute need for more doctors. Excluding retired physicians, the figures for Canada and the provinces were:

TABLE 3

Province	Population per doctor	Province	Population per doctor
Prince Edward Island.....	1,659	Manitoba	1,438
Nova Scotia	1,450	Saskatchewan	2,078
New Brunswick	2,136	Alberta	1,626
Quebec	1,206	British Columbia	1,168
Ontario	1,068	Canada	1,261

The situation was clearly most unsatisfactory in the Maritimes and in Saskatchewan and Alberta, and above all in New Brunswick and Saskatchewan.

There is a particularly acute shortage in mental hospitals and tuberculosis sanatoria. In mental hospitals, according to standards suggested by Ontario in 1942, there should be at the very least one full-time assistant physician (exclusive of superintendent, mental health clinic director, or consultants) per 400 resident patients. In December 1942, the ratio for the Dominion as a whole was approaching the minimum standard; in Quebec it was barely at the minimum, in Saskatchewan, Alberta and British Columbia it was below the minimum. The Medical Procurement and Assignment Board believes that it is now barely at the minimum for the Dominion as a whole. In sanatoria, the accepted standard ratio of physicians to patients is 1:60; the actual ratio in Canadian sanatoria at present is 1:76. Only Alberta and Prince Edward Island are above the standard; and according to the report submitted to your Committee last Session, neither of these provinces is making adequate provision for prevention and treatment, so that the fact that the ratio of physicians in their existing sanatoria is adequate does not by any means indicate that the situation there is all that can be desired.

As for dentists, it is only necessary to note: (i) that in the armed forces there is one dentist per 669 persons, in civil life, one per 3,477; (ii) that the Canadian Dental Association warned the Department of Pensions and National Health that under health insurance it would be impossible to provide full dental service for more than children up to 16 years of age. The Draft Bill makes no provision for meeting this need either.

There is also a very serious shortage of nurses. About 50 per cent of the institutions and organizations answering the questionnaire of the Medical Procurement and Assignment Board reported a shortage. The situation was particularly acute in rural areas, very serious in tuberculosis sanatoria and mental hospitals, and "alarming" in public health work. There was also a lack of nurses in industrial health work. The supply of practising nurses and nurses not now practising but available for practice varied markedly as between province and province.

TABLE 4

Province	No. of nurses per 1,000 of population	Province	No. of nurses per 1,000 of population
Prince Edward Island.....	1.38	Manitoba	1.82
Nova Scotia.....	2.02	Saskatchewan	1.23
New Brunswick.....	1.71	Alberta	1.80
Quebec	1.39	British Columbia.....	3.03
Ontario	2.79	Canada	2.06

It will be noted that Saskatchewan, where the shortage of doctors is acute, has the lowest ratio of nurses of any province, and that Prince Edward Island, whose supply of doctors is also below the minimum standard set by the Board, has the second lowest ratio of nurses. British Columbia's supply of nurses is well above the national average, Ontario's somewhat less so, and Nova Scotia's very nearly up to the national average; all the other provinces are well below it. The contrast between Ontario and Quebec is particularly striking.

With nurses as with doctors, the shortage is particularly acute in mental hospitals and sanatoria. In mental hospitals, counting student nurses as one-half of graduate nurses, and assuming a 54-hour week or longer, the basic minimum standard is one nurse per nine patients; where, as in Ontario and Manitoba, the hours are 48 per week, the ratio would be 1:7.8, or an absolute war-time minimum of 1:8.5 (no allowance for vacations). The actual ratio for ward personnel other than doctors in December 1942 was 1:10.2. Prince Edward Island, New Brunswick, Quebec and Alberta were all below standard, with ratios of 1:10.3, 1:16.5, 1:13.9 and 1:11.0 respectively. The Manitoba situation was deteriorating daily. In sanatoria, the accepted minimum standard of nurses to bed-patients is 1:7, to ambulant 1:3; the actual ratio in Canadian sanatoria was 1:8.3. Manitoba, Saskatchewan and British Columbia were above the standard; Quebec, with a ratio of 1:16.8, was very far below it.

Total immediate requirements of graduate nurses the Board's survey placed at 2,104, of student nurses at 1,562, and of war aides at 751. Under health insurance, the needs are certain to increase.

One reason for the shortage of nurses is undoubtedly the fact that they are being overworked and underpaid, a fact of which the Board's survey offers decisive proof. Forty-nine per cent of the general duty nurses in hospitals get \$849 a year, or less; for mental hospitals the corresponding percentage is 51, for sanatoria, 31. In general hospitals, over 65 per cent of the nurses work more than the 8-hour day or 96-hour fortnight recommended by the Canadian Nurses' Association for graduate and student nurses. For mental hospitals the corresponding percentage is almost 80, for sanatoria about 60. Student nurses in general work from 96 to 140 hours a fortnight.

In order to secure an adequate supply of nurses for the proposed health services, it will in the Congress' view, be absolutely essential to make sure that an equitable share of the available funds shall be allocated to the payment of nurses. Just what allocation is proposed is not clear; but Dr. Charlotte Whitton, in her book, "The Dawn of Ampler Life" (page 131) asserts that the distribution contemplated under the earlier Draft Bill was as follows:—

TABLE 5

Service	Amount per capita	Per cent of cost	Total assigned in payment for each service
Medical	\$9 50	44.0	\$106,485,500
Dental	3 60	16.7	40,352,400
Hospitalization	3 60	16.7	40,352,400
Medicines, etc.	2 55	11.8	28,582,950
Nursing	1 75	8.0	19,615,750
Laboratory	60	2.8	6,725,400
Total.....	\$21 60	100.0	\$242,114,400

As far as the Congress is aware, the correctness of Dr. Whitton's figures has not been challenged. Such a distribution of funds would appear to be unduly favourable to the doctors and unduly unfavourable to the nurses. As Dr. Whitton observes: "on the basis of the number of active registered medical practitioners in the Dominion, this would provide an average income of about \$10,000 per annum in addition to private fees, as against the present average of \$3,142. . . . Such a heavy allocation to medical costs suggests either very substantial increases in the average practitioner's income, or increasing medical personnel by over twice the present total." The Congress has no desire to see either doctors or anyone else underpaid; on the contrary, it urges that all health personnel, doctors, dentists, nurses and others, should be amply remunerated for the vital services they perform. But the division of the available funds among the various categories of health personnel should be equitable, and if Dr. Whitton's figures were true of the earlier proposal, it is to be hoped that they have since been substantially modified, notably in the direction of providing more money for the nurses.

(c) The Draft Bill makes no provision whatever for the very large capital expenditures which are necessary to a first class health service. On the contrary, in the not very liberal grants which it proposes for public health purposes, it explicitly excludes capital expenditures from any consideration. The chief things for which capital expenditures are required are:—

- (i) Two new medical schools, one at Vancouver and one at Saskatoon (where there is now only a two-year course).
- (ii) More general hospitals.
- (iii) Many more special hospitals for the incurable and the chronically ill. At present there are just 20 in the whole Dominion, with a total of 3,415 beds. The provision of an adequate number would considerably relieve the situation in the general hospitals.
- (iv) A great many more special hospitals for the convalescent. Here the shortage is even worse than in the preceding case. There are only ten public hospitals of this type in the Dominion, with a total of 830 beds. There are none at all in the Maritime Provinces, Saskatchewan, Alberta or British Columbia. (These provinces have some private convalescent homes, but they are by no means adequately equipped, and do not begin to meet the need.) Only Quebec, Ontario and Manitoba, it may be added, provide funds for the care of poor persons in this category.
- (v) Mental Hospitals. Our existing mental hospitals are short about 10,000 beds, and this in face of the fact that mental illness is constantly increasing.
- (vi) Hospitals for communicable diseases. There are 14 of these, with a total of 1,713 beds and five bassinets. There are, of course, in addition, special facilities in general hospitals, but the Medical Procurement and Assignment Board's survey describes these as "usually woefully inadequate." There is a particular lack of these special hospitals in rural areas. Practically no rural municipalities and very few villages and towns have anything of the sort. In Nova Scotia, only Halifax has such an institution; Prince Edward Island has none at all. Just how inadequate is the total number of such institutions may be gauged from the fact that Ontario has recommended that there should be a ratio of one bed per 2,000 of population.
- (vii) Hospitals for senile patients.
- (viii) Rural hospitals. The Medical Procurement and Assignment Board's survey reported that Canada has "an unusually fine chain of rural hospitals . . . generally well scattered over the rural areas." But it adds that there are "large" rural areas "with a fair population still

without adequate hospital facilities." Guysboro County, Nova Scotia, with 25,000 to 30,000 people, has only one small Red Cross hospital with four beds. 20,000 to 30,000 people in Cape Breton are at least 35 miles from a hospital; in this area, in winter, it is usually impossible to travel 15 or 20 miles, let alone 35. In New Brunswick, there are three counties, with 42,000 people, which have no hospital whatever, and one county, with 25,000 people, with only one hospital with ten beds. It should be noted that not one of these cases is that of a recently settled, pioneer area; all of them are from old, long settled parts of the Dominion.

- (ix) Many outpost hospitals for remote areas, to deal with the most pressing necessities until the patients can be transferred to fully equipped institutions in larger centres.

(d) Industrial health service. The Medical Procurement and Assignment Board made an elaborate survey of this field. In December, 1942, there were 1,155,307 employees 14 years of age or over in Canadian manufacturing industry. The Board's questionnaire brought returns covering 836,717 of these. The Board laid down as standards: physician, one hour per week per hundred employees (with special consideration for hazardous industries), that is, for plants with 3,000 or more employees, one full-time physician per 3,000; nurse, one per 500 employees. A full-time physician would put in 40 hours per week in strictly professional activities and 10 hours in administrative work. A part time physician would count as one-quarter of a full-time physician.

The results of the Board's questionnaire showed:

- (i) Factories with less than 200 employees were using the services of physicians and nurses for accidents only.
- (ii) In the factories with 1,000 to 3,000 employees, where a part-time physician is usually considered sufficient, there were 29 plants with no physician at all, and 11 others with only a physician on fee basis, a system which the Board considered inadequate.
- (iii) Twenty factories with 3,000 or more employees had no full-time physician, and one had no physician at all.
- (iv) Fifteen factories with 3,000 to 5,000 workers, and five factories with over 5,000 had only part-time physicians.
- (v) There were 220 factories with a physician on salary. In 178 of these there was some degree of general health supervision. This covered a little less than half the employees included in the returns to the questionnaire and about 30 per cent of all employees in manufacturing.
- (vi) In 71 per cent of the factories with over 200 employees (with a total of 200,000 men and 74,000 women employed) there was no organized health service except first aid in case of accident.
- (vii) 350 plants had no physician and no nurse.
- (viii) 43 per cent of those employed had no physical examination.
- (ix) Industry needs the equivalent of 261 full-time industrial physicians, over and above those now working in this field; the need is particularly great in the small and medium-sized plants.
- (x) About two-thirds of the workers are not getting industrial health services.

The Board noted that the benefits of industrial health service lie "in raising the level of general health, in the reduction of absence from work on account of sickness, in improved industrial relations, and in the development of a health consciousness in employees which is an important influence at home."

There would seem to be no question that a vigorous development of industrial health services is urgently required. The Congress urges that any health services legislation should make ample provision for this development, and

that in the drafting and administration of such legislation the organized labour movement should have a prominent place.

4. In this submission, the Congress has not attempted to cover anything like the whole field. Many of the most urgent needs have been amply dealt with in previous submissions by various individuals and organizations, and there is no necessity of burdening the record with a repetition of their evidence. In conclusion, however, the Congress wishes to emphasize that to achieve full health for the nation we need much more than even the best of medical, dental and nursing services can provide. In the words of the British Labour Party pamphlet, "National Service for Health," "if through a sound social and economic policy we can master poverty, we shall thereby do much to eliminate ill health; for poverty is one of the greatest single causes of ill health. If we secure for all good conditions of work, with full employment and ample opportunity for leisure and exercise; if the citizen can obtain well built and well placed houses, with sanitation, water, clean and plentiful milk and other nourishing food, clean air, as much sunlight as possible, and freedom from injurious noise, then the health of the nation will benefit far more from these things than from much doctoring." The best of health services can produce their full effect only if they operate in a healthy society.

Respectfully submitted:

THE CANADIAN CONGRESS OF LABOUR.

A. R. MOSHER,
President.

NORMAN S. DOWD,
Executive Secretary.

APPENDIX "B"

BRIEF OF THE CANADIAN ASSOCIATION OF SOCIAL WORKERS ON
THE DRAFT HEALTH INSURANCE BILL*Foreword*

In this Brief, the Canadian Association of Social Workers expresses its satisfaction at the attention now being paid to the provision of Health Insurance for Canada. On principle, it favours a national scheme of Health Insurance, but recognizing the difficulties inherent in securing a federal scheme, gives its approval to the Heagerty Bill, while recommending certain alterations in it.

These changes would involve public grants to the provinces on the basis of need, modification of the proposed rates of contribution, simpler administrative machinery, the inclusion of a program for the crippled, and the provision of disability benefits.

The necessity for close collaboration between plans for Health Insurance and plans for a national scheme of social security is recognized and stressed.

The Canadian Association of Social Workers is keenly interested in the proposals for Health Insurance for Canada, and strongly approves of the principle of Health Insurance. The Association consequently finds satisfaction in the fact that a good proposal is now receiving serious consideration by Parliament, and it is happy to have the opportunity to present a Brief expressing its opinion of the pending legislation.

Social workers, from the nature of their profession, are in a particularly advantageous position to observe the serious effects of illness on personal and family life; they are constantly combating the social disorganization so caused. Hence they welcome all preventive measures which will reduce sickness and its train of social ills. They warmly approve of these desirable features in the present Bill—universal coverage, including indigents and all income groups; the provision of complete diagnostic and therapeutic services and their integration with preventive measures; and the clear and strong emphasis on prevention which pervades this legislation. These points are strongly to be commended.

Advantages of a National Scheme of Health Insurance

On principle, the Association favours a national scheme of Health Insurance. Sickness knows no provincial boundaries, and there can be no more important matter of national concern than the health of all Canadians. Consequently it regrets that the present measure is an enabling one only, calling for provincial adoption and administration. We are aware of the arguments for this form of legislation—the constitutional difficulties, the dominance of the provinces in health services, and the recommendations of the Rowell-Sirois Commission. Yet it must be admitted that the requirement of provincial action may become an obstacle to the achievement of a national health program.

Under an enabling Act which calls for large provincial expenditures, some provinces will be reluctant or financially unable to enter the scheme, particularly since the Dominion Government, during war time, has taken over the main sources of provincial revenues. These will be the poorer provinces, with low per capita wealth and income. Yet because of their poverty it is these very provinces which have the largest need for health services, both preventive and therapeutic; they have been unable to provide these necessary services for themselves in the past, and have the greatest need for them in the present and the future. Ample evidence of these inequalities of health opportunity are contained in the Report

of the Advisory Committee on Health Insurance itself—startling variations in infant and maternal mortality rates, and in morbidity and death rates, as between the provinces. We submit that a national health policy should strive to eliminate, rather than perpetuate, these inequalities in positive opportunities for good health among our Canadian citizens.

Evidence supporting this view is to be found in the existing social services. Social legislation, left to the provinces, is enacted slowly and often with low standards. Mothers' Allowances, a basic social service first adopted thirty years ago in Canada, are as yet unavailable in two Canadian provinces. Old Age Pensions, though heavily grant-aided, were slow of enactment in the poorer provinces, where the need was greatest. And only in this year, 1943, has the requirement of compulsory school attendance, long accepted in most places by public opinion, been enacted in a large province. If adequate social services are to be achieved promptly there must either be national administration (as with Dependents' Allowances) or else strong federal leadership and participation must be provided.

*Desirability of a Close Relationship Between Health Insurance
and Other Parts of a National Plan for Social Security.*

A second cogent argument for a national scheme lies in the necessarily close relationship between Health Insurance and the other parts of a national scheme of social security. Health Insurance is an integral part of any total scheme and cannot be divorced from it. The arguments on this case are strongly put forward in the Marsh and Beveridge Reports, and need only be mentioned here. The payment of sickness and disability benefits may become unwarrantably high, and the incidence of other forms of dependency—widowhood and orphanhood, and partial disablement and unemployability—increased, with corresponding rises in the cost of these social services. Such increases in incidence and cost are unwarranted because they can be prevented by adequate medical services. The fact remains, however, that only close co-ordination of all social security administration will actually succeed in avoiding them.

A second area where there should be unification is that of machinery for collection of contributions and payment of benefits. The Heagerty Bill will require provincial machinery for this purpose. In considerable part this would duplicate existing Dominion Government machinery, either of the Unemployment Insurance Commission or of the Income Tax Department, both of which are now available and which might be adapted to these ends. Such overlapping and duplication is surely to be avoided. Moreover the principle (and practice) of deductions at source for social services is now well accepted by the population at large, whether through payroll deductions or by income tax payments.

Finally, the British experience points clearly to the necessity for integration of all national social services. After thirty years' experience of unplanned, incomplete and overlapping services in these areas, the recent Beveridge Report recommends their logical integration in a unified, national system under a single Ministry of Social Security. Canada may well ponder and benefit from the conclusion that has been thus forcibly demonstrated by British experience.

The Canadian Association of Social Workers recognizes, however, the difficulties involved in the achievement of a national scheme in this country—the difficulties in securing a constitutional amendment and in the transfer of health services from provincial to Dominion governments. It approves the suggestions of the Marsh Report for co-ordination of facilities for collecting contributions and for payments for family income maintenance. It also is aware of the dangers of centralization in a country so varied as is Canada, and of some advantages in provincial (or regional) administration. *Hence it supports the Heagerty Bill, but wishes to suggest modifications of it in the directions indicated.*

Recommendations

1. (a) That provision be made for grants to the provinces on the basis of need. This recommendation follows from the sections above, indicating marked disparities in ability of the provinces to provide health or social services for themselves.

The grants proposed in the Bill are of two kinds, general grants for health insurance, tuberculosis, mental disease, and public health; and special grants, for venereal diseases, professional training, investigations, and physical fitness. The general grants are either on a per capita basis or are a proportion of provincial expenditures on the appropriate phases of health work. Either of these alternatives may fail to meet the needs of the less wealthy provinces, which have smaller populations, and, being poor, can make only limited expenditures. The special grants are made on a per capita basis, with the same limitation. Only one—that for professional training—is on a basis of need. This is, however, most important, as it constitutes a recognition of the desirability of acknowledging and meeting needs as they arise and where they exist.

We submit that provision should be made for the special public health grants to the provinces, on a basis of need, so that the poorer provinces will be able to provide the same range and quality of health services for their citizens as the wealthier ones. Through such means alone can all Canadian citizens have access to equality of health opportunities.

Hence we would favour the devising of a formula to be followed governing grants to the provinces. This formula should contain factors recognizing population, expenditures, and need. Similar formulae are serving well in Great Britain and in the United States; their use has already been proposed in Canada and received favourable consideration. Suitably weighted, the formula can give due importance to the factor of need, as suggested above. Such a formula simplifies and clarifies the basis of Dominion grants, and is a protection against pressure groups, political and otherwise. We favour its adoption for all the public health grants in the Bill.

1. (b) That the grants for professional training be broadened to include social workers.

Section 3 (first Schedule) of the draft Bill provides funds for the training of professional personnel—public health physicians, engineers, nurses, and sanitary inspectors. Such personnel are certainly urgently needed. Unfortunately, however, social workers, who also have an important contribution to make, have not been included. They should be included.

Social workers have proved their utility in welfare and health programs of all kinds. In Great Britain they are attached to hospitals and health services. In the United States the demand for them has multiplied several times in the past decade, particularly in the Social Security Program, related to the services of Maternal and Child Health, Blind Pensions and Sight Saving, Venereal Disease Control, and in the Crippled Children's Services. They have proved indispensable in such services, and they should certainly be increasingly used in Canada.

Recent Canadian experience strongly supports this claim. In general hospitals, in mental hospitals, in the Department of Pensions and National Health, and in the selection services of the armed forces, social workers have made a large and increasingly valuable contribution. Their services are essential to any form of health insurance scheme. Seven Schools of Social work are now available for training in Canada, and these Schools need support and strengthening. Training grants should certainly be broadened to apply to social workers.

2. (a) That attention should be paid to services for the prevention and treatment of crippling conditions.

Physical crippling, whether from congenital or acquired causes, creates a heavy burden of human suffering and social dependency. Hence modern health programs provide extensive measures of prevention and therapy. The Crippled Children's provisions of the Social Security Program of the United States is an excellent example.

A similar provision is called for in Canada, with broad features of registration, medical and surgical treatment, education, vocational training, placement, and supervision. On the financial side such a scheme would more than repay its cost in one generation, by the reduction of costs of invalidity and social dependency. More important, on the human side, such provision would reduce suffering, bring cheer and hope into warped lives, and create from a group of potential dependents a body of healthy, contributing citizens. It should therefore be incorporated in the present Bill.

- (b) Provision should be made for a broad national program of Vocational Rehabilitation.

This scheme is mentioned here, as it is closely related to 2 (a) above. In administration, however, it is related both to therapeutic services and to the prevention of invalidity in a scheme of national social insurance. Hence it is fully dealt with in a (later) brief by this Association on the Marsh Report.

3. *That the proposed complicated contributory scheme be simplified*

The Bill provides several rates of contribution for different marital classes—3 per cent of the annual income for a single person, up to a maximum of \$26 per year; 3·7 per cent for a married man, to a maximum of \$52 per year; 4·3 per cent and 4·9 per cent for a married man with one or two dependents over sixteen, to maxima of \$78 and \$104 respectively.

This proposed contribution scheme contains some curious anomalies and injustices. The first of these concerns the rates of contribution of a single man and a married man without dependents. Take the case of a single man earning \$800 per annum, in comparison with that of a married man earning the same amount. The single man pays \$24 a year in contributions and the employer pays the balance of \$2. This is an admission, in effect, that the single man earning \$800 is not financially in a position to pay his full premium. If this is the case with regard to a single man, it is surely the case also with regard to the married man earning \$800. If the single man at \$800 can only pay \$24, the married man at this same amount can certainly not be considered able to pay more. Yet when we come to the proposals in the Bill, we find that the married man has to pay at the rate of 3·7 per cent rather than the single rate of 3 per cent.

Moreover, there seems to be a further injustice to the married man with dependents over the age of 16. (Children under 16 have their contributions paid by the government). To assess costs of \$78 and \$104 on families and four older children seems wholly unjust. It is a direct and heavy penalty on the family which seeks to do well by its children by giving them a good education in secondary school, business college, or university. This inequity surely calls for remedy.

In the Marsh report, the income figures presented in Section 3 show that one-third of urban wage earners who are heads of families have incomes below even a minimum level of subsistence, and that two-thirds of urban wage earning heads of families have incomes below a desirable living minimum, necessary for the maintenance of decency and health. This large body of low income families in the Canadian picture certainly deserves aid and not penalty for a contributory scheme.

These anomalies, together with the differential rates of contribution for the different classes and the complicated scheme of contribution by employers and provinces, makes for confusion and apparent inequity in the whole contributory

scheme. We suggest, therefore, that both single and married persons should pay a uniform rate of 3 per cent up to the maximum of \$833 per annum. At that point the single person reaches his full premium of \$26 and stops there. In the case of the married man, however, he might be expected to pay 3·7 per cent of his income over and above \$833 up to the maximum figure which would produce the full premium of \$52 for a married couple. This principle, applied throughout the family range, would ease the burden slightly on married couples with dependent children over 16.

Deficits for dependents should be made up primarily by contributions from governmental sources, such as tax funds which are collected on the basis of ability to pay. We submit that this would be a simpler, more understandable, and more equitable arrangement than that now proposed.

4. That the form of the administrative bodies be modified

(a) National.—National administration is placed in the hands of the Minister of Pensions and National Health, with the advice of a National Council on Health Insurance. This body is representative of the provincial administrations and of professional groups. Its powers and duties, however, are not stated, and it may meet only once annually. We do not believe that the entire administration should rest exclusively with the members of the medical profession; we do believe that such administrative bodies should have a broad representation. Consequently we submit that:

1. The National Council on Health Insurance should be broadened to include representatives from various groups,—dentists, pharmacists, nurses, social workers; farmers, trade-unionists, and citizens; and, particularly, insured persons who are the consumers of health services, and who, perhaps, more than any other groups, are entitled to representation on policy-making bodies.

2. That the National Council, so enlarged, be an Advisory Council to the Minister of Health, and to it be referred all major matters of policy for consideration and recommendation to the Minister.

3. Consistent with its status and importance, the National Council should meet at least quarterly.

(b) Provincial.—Provincial administration is placed in the hands of a similar commission. A large amount of important administrative work is to be done at the provincial level, and we believe that such a body would be somewhat unwieldy and ineffective for this purpose. As an alternative we believe that the proposals of the Deputy Ministers of Health is sounder—namely, that provincial administration should be through a Director of Health Insurance, under the Deputy Minister of Health, or else by a three-man commission. In either case, there should be created a representative Provincial Advisory Council, available to the Director of the Commission for reference and consultation. This Council, also, should provide for wide representation of laymen.

(c) Local. Administration at the Dominion and provincial levels is important for planning and policy formation. But the day administration of any health or welfare scheme comes at the local level,—in the city, town, or county; here human needs are met. The realities of administration are very real at this level. Hence there is equal need of local advisory committees, related to the local health insurance officer. Through them all matters of major policy should be cleared. Such local committees, comprising an interested group of laymen, can aid materially in keeping local administration efficient and alert to changing community needs.

5. The maintenance of family incomes in periods of illness of a wage earner should be provided for under a National Social Insurance Scheme

The purpose of a cash benefit in any social insurance is the maintenance of family income, to prevent sub-standard living and destitution. The family whose wage-earner is sick at present suffers a double disability—its income is cut off,

and at the same time its expenses are increased to provide for medical care of the sick member. Additional responsibilities and strains are thrown on the wife and mother, and hence family disorganization tends to result. The proposed scheme would provide medical care but does not include income maintenance, so necessary to the family's security in times of illness.

Income maintenance is properly the function of a national scheme of social insurance, as is recognized in the Marsh Report. The Rowell-Sirois Report suggested that collection and payment of a sickness benefit for insured persons could be achieved by expansion of the Unemployment Insurance machinery. Were that machinery to be modified to become a National Social Insurance Commission, as proposed by the Marsh Report, sickness and other benefits would be incorporated in the national scheme.

We would point out a particular need for sickness cash benefits for those now covered by unemployment insurance. Such insured persons will draw cash benefits (approximately half their normal rate) when unemployed but able and willing to work. If, however, during a benefit period they are temporarily disabled by sickness, their unemployment insurance benefit is suspended for the period of illness. This leaves them without any family income, even though they are insured persons, though their needs for income are in fact actually larger than before. Such persons will find this stoppage of benefit difficult to understand and apparently unjust. Undoubtedly there will be a strong demand for the continuation of benefits during short periods of illness—in fact, for a cash sickness benefit. We suggest that this situation be anticipated, and that immediate plans be made for the provision of such a benefit. This awkward, but important gap, is but another example of the lack of thorough and integrated planning for a national social security program.

We recommend, therefore, that immediate consideration be given to a scheme for the maintenance of family incomes in the case of illness of a wage earner. Such provision should be a part of the National Social Insurance Scheme, as recommended by the Marsh Report.

Conclusion

In conclusion, the Canadian Association of Social Workers again wishes to express its satisfaction that the nation's health is receiving such intelligent attention, and that such an excellent proposal has resulted. It considers it unfortunate, however, that the Health Insurance measure was planned and considered independently of a national scheme for social security, of which it should be an essential part. Because of the necessary connection between health and social security measures, our Association endorses the proposals of the Marsh Report that close co-ordination of all future planning is essential. The resulting Health Insurance measures would then be an integral part of a truly national and effective scheme of social security for every Canadian citizen.

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Canada Social Security, Spec
Comm on, 1944

SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 8

TUESDAY, MAY 2, 1944

WITNESSES:

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. R. B. Bryce, Financial Investigator, Department of Finance.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



MINUTES OF PROCEEDINGS

TUESDAY, May 2, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Blanchette, Bourget, Bruce, Cote, Donnelly, Gershaw, Gregory, Hatfield, Hurtubise, Johnston (*Bow River*), Kinley, Lalonde, Leclerc, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Nicholson, Veniot and Wright.—23.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance.

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. J. C. Howes, Research Staff, Bank of Canada;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;

Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics.

Hon. Mr. Bruce expressed his desire to refute certain statements made by Mr. J. W. Fulton at the previous meeting. After discussion this was acceded to.

The Committee then proceeded to consider the draft Health Insurance Bill.

The following witnesses were called, examined and retired:—

Dr. J. J. Heagerty, Mr. Gunn, Mr. Watson and Mr. Bryce.

Clause 1 adopted.

Clause 2 adopted.

Clause 3 stand.

Clause 4 stand.

On motion of Mr. Maybank the Committee adjourned at 1.05 p.m. to meet again at the call of the Chair.

J. P. DOYLE,

Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

May 2, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: At the last meeting Mr. Gunn was asked to draw up a clause with reference to exemptions which might be satisfactory. It was also suggested that he consult the advisory committee on health insurance. He did that. There is not unanimity with regard to the clause. The advisory committee on health insurance has drawn up another clause which has been submitted to the Department of Justice for comment. I therefore suggest that we do not proceed with the discussion of this clause this morning because one is not available, and that we go on with the bill leaving contentious matters to be considered later. If we go on with the bill this morning we can agree on certain sections of the bill leaving for later discussion contentious material. If we proceed with the bill I suggest from the chair we proceed in camera. That is the general practice. What is the will of the committee?

Hon. Mr. BRUCE: Mr. Chairman, I dislike very much, to begin with, having to disagree with your ruling because I have a very high regard for you.

The CHAIRMAN: It is not a ruling; it is a suggestion.

Hon. Mr. BRUCE: But I think certain matters developed on the last occasion which should be cleared up here. I am referring to your ruling on that occasion when—I have the exact words here—you declined to have any discussion in open session on the question of Christian Science treatment, and said that these matters should be considered in camera. Because of your attitude I discontinued any further discussion at that time, but I venture to disagree with that ruling for these reasons. The representative of the Christian Science faith, Mr. Fulton, presented a brief a year ago. He presented another brief on the last occasion and supplemented it in the committee with an argument setting forth the doctrine of Christian Science, a great deal of which could be the subject of controversy, and with a great deal of which I would disagree. As he did this in open session and gained wide publicity for his statements I think we should have the opportunity of discussing also in open session what he said here. I do not agree it is a question which should be discussed in camera or in secret session, and I hope that you, Mr. Chairman, are not going to get the infection which has happened elsewhere where certain matters have to be considered in camera, or where a decision has been reached to hold them in camera.

The CHAIRMAN: I am immune from that infection.

Hon. Mr. BRUCE: I am glad to know that.

Mr. DONNELLY: I think there are certain things should be held in camera.

The CHAIRMAN: On this particular case.

Hon. Mr. BRUCE: There is the further reason that we are asked here as a committee to approve of granting benefits to a certain cult to practice medicine because that is what they are asking. We are asked to diagnose their cases and then turn the cases over to them, not that they need a diagnosis in order to treat the case, but in order to protect them or protect the government, as Mr. Fulton said, against charges for services which might be considered improper. In other words, they want to be sure that the patient is sick and that the patient requires treatment.

I take it that we are here as members of parliament to protect public funds. A large amount of which will be placed at the disposal of those administering the health insurance Act, which funds will be contributed by the dominion government, and the source of which is the taxpayers' pockets. If that is so then I say it is perfectly proper and a duty that we should protect the taxpayers against paying out money for a kind of treatment which some of us believe has no value and, I might say, against fraud. Therefore, Mr. Chairman, I submit that this is the place to consider in the open any representations which I, or any other member of this committee, wishes to place on the record giving our opinion from experience as to the reliability of the claims made, and as to whether we consider that we would be justified in recommending that public funds should be used for that purpose.

Therefore, I am going to ask that I be permitted to continue to make a few observations as the result of my own experience in a practice of over forty years in surgery during which time I came into contact with many so-called Christian Science healers. I notice the term now used by Mr. Fulton is Christian Science practitioners. I should like to make a few observations not only from my own experience but from the written record of the work of these healers as placed at the disposal of the public, and which I have taken the trouble to look up, showing just what results have occurred as a consequence of their freedom to practice in the United States.

Mr. JOHNSTON: Do I understand we are going to debate this now?

The CHAIRMAN: No, I am just waiting until Dr. Bruce finishes his preliminary remarks. He is protesting against the ruling of the chair at our last meeting.

Hon. Mr. BRUCE: I wish to refer, in addition to my own experience on which I will make some observations later, to a book published by Fleming H. Revell and Company, New York, Chicago, London and Edinburgh on the Faith, Falsity and Failure of Christian Science, by Woodbridge Riley, Ph.D., member of the American Psychological Association, Lecturer at the Sorbonne, 1920; Author of "American Thought from Puritanism to Pragmatism".

Mr. JOHNSTON: Mr. Chairman, on a point of order I think Dr. Bruce is going further than appealing your ruling. If we are going to allow such remarks to be put on the record then certainly they will have to be answered because I am going to take objection to some of the statements he is making right now.

The CHAIRMAN: The ruling of the chair last time was based on a certain conviction. There are two things in this regard which this committee should do before this bill is finally disposed of. First we must decide who shall be exempted from the provisions of the proposed bill. Shall any individuals or groups of individuals be exempted? We have decided that we must decide who these groups of individuals shall be. The question of exempting Christian Science or any other form of treatment has not yet been decided. It will come under section 10 when we reach that section in the second schedule with reference to benefits. I expressed the conviction of the chair last time that this is not the place to discuss the relative merits of various kinds of treatment. We should not turn this committee into a medical clinic or into a place of discussion of medical practice because such a discussion would be endless, and will be endless. Either we drop this bill and say we cannot go on with it because of differences of opinion which should not exist, in my judgment, or we get on with the bill. This committee has to decide and take the responsibility for whatever action we take. I still contend that we cannot discuss medical practice and methods of practice in a public session. If we wish to discuss them in camera that is a matter for the committee to decide. That is my ruling.

Mr. MAYBANK: Mr. Chairman, my understanding was—and I am just saying this so as to be corrected if I am wrong—at the conclusion of the last meeting

that we had tentatively decided upon an amendment to the Act which, in effect, declared the question to which Dr. Bruce has now addressed himself to be a provincial matter.

The CHAIRMAN: Yes.

Mr. MAYBANK: And not ours. That was, as I thought, the sense of the meeting when we closed. We asked Mr. Gunn to prepare some sort of draft to import that into the Act. I may be wrong, but that was my understanding at that time. I thought that by making it clear that this problem is not a dominion problem but a provincial problem, and putting that into the Act, we would thus obviate all this very type of discussion upon which the hon. doctor has embarked this morning. I think if we carry on that way we probably could have the legal amendment proposed laid before us and deal with it now.

The CHAIRMAN: We cannot deal with it now because it is not available at the moment. There are two amendments to come before the committee but one is in the hands of the Department of Justice for study at the present moment, and will not be available to-day. That is why at the beginning of the meeting I suggested that this contentious matter be deferred.

Mr. MAYBANK: I am not expressing any objection. I was only trying to recall to us all that we made that decision.

The CHAIRMAN: I agree with that.

Mr. MAYBANK: Frankly I do not think this is our baby at all. I do not think it is a question for us as to whether a person should be healed by faith and prayer or by pills.

Mr. DONNELLY: If this amendment to the Act is not here at the present time I would move that we go on and discuss the bill as it is.

The CHAIRMAN: The non-contentious parts.

Mr. DONNELLY: The non-contentious parts of the bill, until that amendment that we want to the Act from the Department of Justice is ready for us to consider, anyway.

Mr. McIVOR: Mr. Chairman, I would second that motion. I think every member of the committee wants to be fair. You want to be fair and I want to be fair, I do not care whether it is Christian Science or something else. But the doctor prejudiced his case when he said, "Some of us think that this treatment is of no value." He may think that.

The CHAIRMAN: Order.

Mr. MAYBANK: You are going right into it again.

The CHAIRMAN: You are again off the beam a bit.

Mr. MAYBANK: Mr. Chairman, I rise to a point of order. The eminent divine is following the eminent doctor to do evil. They are both out of order. You do not take that seriously, Dr. Bruce.

Hon. Mr. BRUCE: I do not think that deserves an answer, really. I should just like to point this out, Mr. Chairman. You have stated that we cannot discuss medical practice. I do not propose to discuss medical practice.

The CHAIRMAN: Not in public session.

Hon. Mr. BRUCE: You say not in public session. I am not proposing that we should discuss medical practice at all. This is not medical practice.

The CHAIRMAN: Healing practice.

Hon. Mr. BRUCE: Never mind; it is not even that in so far as certain diseases are concerned. I should like to reply to that. I wonder whether some gentlemen who are so anxious to avoid any discussion on this would consider the position that a child or a young man developing cerebro spinal meningitis would be in.

Mr. JOHNSTON: Order, Mr. Chairman.

Mr. DONNELLY: This is going to go on into an endless discussion.

Hon. Mr. BRUCE: If you allow that disease to get beyond a certain point—

The CHAIRMAN: Order. I am going to put the motion of Mr. Donnelly.

Hon. Mr. BRUCE: Very well. I will just say this. If I am not allowed to discuss the statement made by Mr. Fulton at the last session and you rule that this must be the subject of a secret session, in camera, then I will withdraw from this committee, because my usefulness here has ceased.

Hon. Mr. MACKENZIE: May I just say a word. I think your ruling, Mr. Chairman, is absolutely to be commended, but I do see Dr. Bruce's point of view. I think it was a great mistake to allow any further evidence at all at the last sitting of this committee. I think we should have closed out the hearing of evidence. From a long experience with committees, I would say that the general practice has been that once the evidence is closed, and all the evidence is in, the committee sits by itself. It is not necessarily an in camera session but purely a business session of the committee to discuss the matter clause by clause. We had that in the case of unemployment insurance and other measures, and that has been the procedure for many years. I do see Dr. Bruce's point of view; certain allegations having been made here he felt, as a matter of professional interest, that he would like to answer them. I can see his point of view. But I do say that if we are going to make any progress in this committee, we must close up our hearing of evidence from now on and go on with the executive discussion of the bill clause by clause.

Hon. Mr. BRUCE: In answer to that, Mr. Chairman, may I say that I have sat on the committee where in camera consideration was given to the rules and regulations. That is not a place where we have the opportunity of entering into the discussion I purpose entering into here. Certain statements were made by Mr. Fulton which I think should be answered and should be answered here. I will refer to just one—this is not medical healing—and perhaps the chairman will allow me to do so.

The CHAIRMAN: Yes.

Hon. Mr. BRUCE: Mr. Fulton made a statement on page 196 as follows:

I have represented the Christian Science organization in the province of Ontario for close on fifteen years, and I can tell you that there is not one case in the whole of the Dominion of Canada in twenty-five years in which there has been any action taken against a Christian Science parent for failure to protect his child.

Mr. Chairman, that is an untrue statement. I refer you to page 451 of the Dominion Law Reports, volume 3, 1925, in the case of *Rex v Elder*. I do not need to read the whole case here.

Mr. MAYBANK: Mr. Chairman, the dates show that what Dr. Bruce is saying is incorrect. Apparently he is dealing with that fifteen-year period, and now he is quoting from a 1925 Law Report which is more than fifteen years ago.

Hon. Mr. BRUCE: Excuse me. I am one year within it.

Mr. MAYBANK: Oh, yes, I beg your pardon, twenty-five years.

Hon. Mr. BRUCE: Just let us be fair. I am not a lawyer.

Hon. Mr. MACKENZIE: You are just under the wire.

Hon. Mr. BRUCE: I want to be correct, that is all. Briefly, this is a case in which a young girl, the daughter of Mr. and Mrs. Watson, was taken ill. They were Christian Scientists. The daughter, Doreen, was taken ill.

Mr. LALONDE: From which province was that case?

Hon. Mr. BRUCE: I think it was in Manitoba, the province from which Mr. Maybank comes, and he will perhaps be familiar with this case. It is before Chief Justice Perdue. The girl, was Doreen Watson, twelve and a half years old. The parents were Christian Scientists. They called in a Mr. Elder, a Christian Science healer, and he treated her from November 5, on. Later on, on Tuesday, November 11, Dr. Fraser, was called in and he describes her condition as follows:

Her nostrils were completely obstructed so that she could not breathe through them. Lips and mouth were dry and cracked. There was an irritating discharge from the nostrils which were red and irritated. The breath was exceedingly offensive. The glands of the neck on each side under the jaw were quite swollen and prominent. Both tonsils were covered with a dense, heavy, gray membrane which extended across the uvula and up into the nasal cavities. Where the throat was not covered with membrane it was red and inflamed.

He took a swab which showed it to be diphtheria. Later on Mr. Elder abandoned the case or left the case and another Christian Science healer was called whose name was Robb. The patient ultimately died.

Mr. JOHNSTON: In his own experience did the doctor ever have a patient who ultimately died?

Hon. Mr. BRUCE: That is not relevant at all.

Mr. JOHNSTON: Yes, it is, Mr. Chairman.

Hon. Mr. BRUCE; I beg your pardon. It is not relevant to this case.

Mr. JOHNSTON: I will bet that there may have been several instances at least in the doctor's own practice where similar results may have occurred.

Hon. Mr. BRUCE: The patient would not have died if she had had antitoxin at an early stage, at the time the Christian Scientist was attending her. Because of the viewpoint of Christian Science she was denied the opportunity of having appropriate, specific treatment.

Mr. McIVOR: I do not think there is a doctor here but would say that sometimes he just did not completely understand the effect of treatment. I have seen doctors heartbroken because they were not able to carry their patients through. I think that the question is relevant.

The CHAIRMAN: You realize what I meant by "endless discussion".

Mr. DONNELLY: And useless.

Hon. Mr. BRUCE: If I may be allowed to finish I should like to do so. As I said a moment ago this case was tried in the courts of Manitoba; I presume in Winnipeg. The action failed only because it could not be proven that the healer aided and abetted. The charge in that case was manslaughter. There are a number of other cases quoted here but I am not going to burden the committee by reciting them. They will be found in this law report.

I should just like to comment here on something that was brought before us by Mr. Slaght on the last occasion, and that was the question of the Criminal Code. Mr. Slaght pointed out, as also did Mr. Fulton, section 241 of the Criminal Code which makes it a duty for the person in charge to provide the necessities of life, and it is a criminal responsibility to fail to do so. It has been decided in the courts that medical aid is a necessary within this section. The neglect of a parent or person in charge to provide a person under his charge with medical treatment constitutes criminal neglect under this section, and any person counselling or abetting such offense, is equally guilty.

May I recall that Mr. Roebuck, who appeared before this committee, told us that he had been the advisor and counsel of the Christian Science organization for twenty-five years. I may say that great care is used by the Christian

Scientists to avoid this clause in the Criminal Code. The way it is done is this. If the patient is very ill and apparently about to die, a medical practitioner is called and he signs the death certificate. If he signs the death certificate, then it does not come before the criminal authorities. That is the method used to avoid responsibility under this section of the Act.

Mr. JOHNSTON: The doctor who signed the death certificate is really liable, though.

Hon. Mr. BRUCE: Well, yes. As for myself, I believe that a doctor, who comes in at the last minute and signs a death certificate under the circumstances I have just mentioned, is acting improperly.

Mr. McCANN: Excuse me, Dr. Bruce, but is it not the practice—I know it is in Ontario—that a case like that is referred to the coroner and the coroner, after investigation or public inquiry, signs the death certificate?

Hon. Mr. BRUCE: I am told by the Registrar of the College of Physicians and Surgeons of Ontario that the matter is not necessarily referred to the coroner, and the means of avoiding such reference is the step that I have just mentioned.

I do not wish to proceed any further with that. If the chairman's ruling is such as he mentioned a moment ago, and I take it that it is, then my usefulness in this committee has ceased and I am going to retire.

The CHAIRMAN: Oh, no.

Mr. MAYBANK: May I add a word here?

The CHAIRMAN: Just a minute. What is your crave, Dr. Bruce?

Hon. Mr. BRUCE: I beg your pardon, Mr. Chairman?

The CHAIRMAN: What do you wish?

Hon. Mr. BRUCE: I wish to present to this committee certain information which I as a medical man have acquired over a long period of years and which would be helpful to this committee in deciding whether they are willing to have public funds spent in giving the Christian Science healers a right to practise under this Act. That is the first thing. Secondly, I wish to quote from the book to which I referred, which was following an investigation extending over the years by eminent men in the United States. I mentioned Dr. Riley, Ph.D., with whom were associated Frederick W. Peabody, L.L.B., a member of the Massachusetts Bar and Charles E. Humiston, M.D., Sc.D., professor of surgery, College of Medicine, University of Illinois. Now, I can give the committee the preamble to this book and the conclusions in a few words, and I would like to do so.

The CHAIRMAN: Dr. Bruce, are you willing to have that done in camera?

Hon. Mr. BRUCE: I am not willing to have it done in camera. I want it to receive the same publicity that the representative of the Christian Science cult received for his statement when he claimed the right to treat patients under this Act.

The CHAIRMAN: In other words, you wish to question the last witness?

Hon. Mr. BRUCE: I am questioning the statement made by the gentleman who appeared here.

Mr. DONNELLY: May I ask one question? Are the Christian Scientists recognized by the province of Ontario at the present time?

Hon. Mr. BRUCE: They are allowed to practice, but they do not get public money.

Mr. DONNELLY: Do they receive recognition from the province of Ontario? Are they allowed to practice?

Hon. Mr. BRUCE: Yes, they are allowed to practice; they practice their faith there but they do not get public funds. That is what I am objecting to.

If any individual is going to pay healers for so-called treatment, well and good, that is their privilege, but I object to public funds being used for that purpose.

Mr. NICHOLSON: Are they paid under the Workmen's Compensation Act?

Hon. Mr. BRUCE: No, they are not.

The CHAIRMAN: Dr. Bruce, how long would it take you to make your presentation?

Hon. Mr. BRUCE: I think ten or twelve minutes.

The CHAIRMAN: Well, on the understanding that the evidence will be completed with Dr. Fulton's statement given at our last meeting, and that then we shall proceed in camera to discuss this bill, I shall allow that.

Mr. JOHNSTON: Mr. Chairman, do I interpret your order to mean that you are going to allow Dr. Bruce to give a statement in regard to this matter without any answer being made to that statement, and from then on you are going to close the door on the matter? Surely that is not so?

The CHAIRMAN: I am going to permit Dr. Bruce to refute certain statements that were made by the last witness. He has refuted one or two of them now. But after he has made his statement, evidence as such is ended. That will not cut off the discussion.

Mr. JOHNSTON: Are you going to allow Dr. Bruce to discuss Christian Science medical practice, or their practice in healing, because if so that throws the whole question into the open.

The CHAIRMAN: I am going to allow Dr. Bruce to review certain statements that have been made in a supplementary brief.

Mr. JOHNSTON: I would object to that, Mr. Chairman, most strenuously. I think it is most unfair.

Mr. MAYBANK: Mr. Chairman, with all respect I think it is unwise to open this matter any further at this time because I may say that it cannot be closed off. Personally, I would like to hear what Dr. Bruce has to say; I think his statement would be informative; but I may say now, in view of the fact that he seems to think I am a protagonist of Christian Science versus medicine, that he is quite wrong if he has drawn any such conclusion. My only reason for pressing the point, as I have done, is that I think this is a provincial matter. Dr. Bruce used the expression that we are asked to approve granting benefits to a cult. I think that is a mistaken conception—certainly it is a mistaken conception of my attitude. My attitude is solely that we should not get tangled up with this matter because it is not our baby. I am not a protagonist for Christian Science at all; I have run much more—well, almost entirely with Dr. Bruce in these matters.

The CHAIRMAN: Dr. Bruce's request of the committee is that he be given ten minutes to refute certain statements that were allegedly wrong, as I understand it.

Mr. MAYBANK: Of course, that would not interfere with me—

Mr. LALONDE: Mr. Maybank tells us that this is not our baby. He is quite right. I am asking myself whether it is wise to leave the door wide open to the provinces to apply the law that the federal government will pass to any kind of—I would not say medical association—but healers or groups.

The CHAIRMAN: Is not that the established right?

Mr. LALONDE: In my opinion I think we have a responsibility to put a certain limit to expenditures of federal funds; but I understand that we are in a very difficult position. A public statement has been made before the committee by Mr. Fulton, and I realize that Dr. Bruce desires to answer that

statement publicly. I would agree with him, but we are on very slippery ground; we are getting into religious matters. As I am not a Christian Scientist I may say that in our religion too we have a certain faith in the curing powers of prayer, let us say, in the Catholic religion, and we do ask God to give aid to human beings. I may say to the committee that if we allow Christian Scientists to apply for the right to be paid out of federal funds, then I do not see why our nuns or Brother André, for example, from Montreal, or members of some other religious groups should not apply for the same privilege.

Mr. MAYBANK: That is right.

Mr. LALONDE: That is how I see the picture. I do not want to make any obstruction. I am much impressed with Dr. Bruce's statement, and I want to be fair to Mr. Fulton and all the other groups applying to this committee; but my viewpoint is that I would agree with the chairman's ruling that this question should be fully discussed in camera, because we are stepping on very slippery ground. Therefore, I am going to appeal to the fairmindedness of Dr. Bruce to accept this suggestion, and if he is not satisfied afterwards, I suggest that he be permitted to make a public statement later on which would be put on the record showing his opposition to Mr. Fulton's request. We are in a very difficult position with regard to Mr. Fulton's proposal, because we are on religious ground.

Mr. JOHNSTON: Mr. Chairman, I would like to appeal to you for justice in this regard. You will note that Dr. Bruce said he had two main concerns, and one was publicity. He wanted the same publicity given to the statement he is to make as was given to the statement made by Mr. Fulton. Now, surely, this committee is not concerned with publicity, at least I am not.

The second main objective which Dr. Bruce had was to stress the fact that the Christian Scientists might get moneys voted by the public, or public moneys, or a portion of the public money. I take it from that statement that he wants everybody else excluded from receiving public moneys under this bill except the medical profession. Those are the two main points; those are his own words. I object most strenuously if you allow him to go on and discuss practices which are employed by Christian Scientists and of which he does not know any more than the Christian Scientists would know about medical practice. I would object to Mr. Fulton coming up here and discussing the practice of medical doctors, because I do not think he would be competent to do so. I am making the same objection as regards Dr. Bruce. I think we should be very careful in this matter.

The CHAIRMAN: Dr. Bruce wishes to refute certain statements that were made by a witness which his own knowledge convinces him to be contrary to the facts, and he says he will take only ten minutes to do it. I don't think it is a question of publicity, it is a question of putting before the public the two sides of a controversial question.

Mr. LECLERC: Mr. Chairman, will that amendment open the door to all other healers? We cannot treat Christian Scientists in a different way from chiropractors and other kinds of healers. Personally, I do not have unlimited faith in the doctors, but certainly I have more faith in doctors because they have made a study of medicine. The point is, will this open the doors to all the other healers who will want to be included?

The CHAIRMAN: The amendment is not available for discussion, Mr. Leclerc, at the moment; I do not know what it contains.

Mr. COTE: If Dr. Bruce is permitted to proceed, well then the committee, to be fair to the Christian Science group, would have to allow a reply, otherwise Dr. Bruce will have the last word on the matter.

Hon. Mr. BRUCE: I may state that I would be quite willing to have Mr. Fulton reply to me on behalf of the Christian Scientists.

Mr. MAYBANK: Then you have sur-rebuttal, rejoinder and sur-rejoinder.

Hon. Mr. BRUCE: I would like to say a word in reply to the statement made by Mr. Lalonde—

Mr. JOHNSTON: Are ten minutes only allowed?

The CHAIRMAN: Not necessarily; about ten minutes.

Hon. Mr. BRUCE: Mr. Lalonde says that this is a religious matter, and in some ways, I presume, interferences with religious freedom. I do not think, Mr. Chairman, that it is a religious question. All of us who practice medicine know that the representatives of the clergymen or priests of all denominations, in the case of serious illness affecting their parishioners, pray for them, for which service they do not make a charge. We not only do not object to it; we welcome it. Therefore, Mr. Lalonde, it in no way interferences with religious freedom. I maintain that this is not a question of religion at all. Mrs. Eddy, in 1881, established a college which she called the Massachusettes Metaphysical College to teach certain tenets of healing which it is alleged in the book to which I referred she got chiefly from an occultist healer to whom she applied for treatment in 1862—a man by the name of P. P. Quimby—and her system was based on what she discovered by having treatment from Quimby. She used his methods as a method of healing. It was only after carrying on this college for seven years, and when threatened with prosecution by the District Attorney in Boston, that the college was closed, and shortly afterwards a church was established.

Now, as I am only allowed a very short time, I would like to put into the record statements made in the preface of this book and conclusions arrived at by the gentleman to whom I referred a moment ago and for this purpose will give them to you now.

In the foreword to this book which is entitled "The Faith, the Falsity, the Failure of Christian Science", they have this to say:—

The authors of this volume recognize the right of every adult freely to exercise his choice of religious belief and medical treatment. A responsible, conscious adult may employ any form of treatment for his own physical ills, or dispense with all forms. It is his right to suffer, unrelieved by medical skill, and to die, unattended by a medical doctor, if he wishes.

This book is written because the authors strongly feel that no one has the right to withhold medical attendance and treatment from any sick and suffering child, or from any adult incapable, because of his condition of personal judgment. That barbarity should not be permitted.

Christian Science professes to be a religion and an infallible curative agency. It denies the efficacy of medical science and withholds medical treatment. The operations of its "healers" are precisely the same as total neglect. The results, especially in the case of children, are hideous beyond description.

Inasmuch as Mrs. Eddy's religious pretensions and her claimed discovery of a cure-all healing system are wholly false, the authors believe that the most effective cure of the Christian Science distemper, at any rate the best way of preventing its spread, is to present in plain terms the evidence of the Eddy imposture and of the results of the uncontrolled operations of the "healers". To this end, Dr. Riley, after a most careful investigation of the sources of Christian Science, here shows precisely where Mrs. Eddy derived every feature of her religious and therapeutic system. Dr. Humiston, by many cases selected from a mass of data gathered by a nationwide questionnaire, shows the tragic results of Christian Science treatment of helpless adults and still more helpless children. Horrible as are the cases presented, Dr. Humiston deemed

some of his discoveries too ghastly for publication in a book designed for general distribution. Mr. Peabody, in terms that will be familiar to readers of his Religio-Medical Masquerade, demonstrates the complete unverity of the so-called discoverer and founder of Christian Science, her frantic money grabbing, her literally insane grasping for absolute power over her followers, and leaves no doubt that the present government of organized Christian Science zealously emulates its predecessor.

After weighing the evidence in a volume of 402 pages, they end up with the following conclusions:

From the medical standpoint Christian Science, as a system of treating human ailments, is thus seen to be a cruel failure. The best that can be said of it is that it may divert the patient's attention while other factors make for the cure of his infirmity.

The worst that should be said of it cannot be uttered, as mere words are wholly inadequate to depict the iniquity of this nefarious traffic in human life. Christian Science, shorn of its mask of religion, stalks forth the arch-demon of the medical underworld. The nearest to a true estimate of the value of this fake therapeutic agent is recorded only in the churchyard.

Christian Science is an assassin of humanity. To every form of human misery it brings its one offering—arrogant, boastful, criminal ignorance. It obtrudes its hateful presence between suffering humanity and the only known means of relief. It supplants surgery with sorcery and tender solicitude with brutal neglect. With hostile mien it stands guard against curative medicine at the bedside of childhood while death strikes down the helpless babe. Christian Science is the advance agent of scourge and pestilence, the ally of smallpox and consumption, the confederate of appendicitis and typhoid fever, and the executioner for cancer and intestinal obstruction.

Against every victory of scientific medicine, Christian Science makes angry protest. Every advance in preventive medicine is fought through in the face of virulent opposition from this miserly-fisted parasite.

Highwaymen demand: "Your money or your life". Christian Science, beguiling with siren smile, deluding with false promise, takes your money and your life.

Gentlemen, I should like to take one or two minutes more of the time of the committee to refer to a case in my own practice of a woman of sixty years of age with cancer of the intestine producing obstruction. She was under the care of a Christian Science healer for many months. It was only when complete obstruction occurred that some of her friends urged that a medical man be called in and when he arrived he sent her into the hospital and telephoned me to meet him and examine the patient, which I did. I performed an immediate relief operation which we call colostomy. Following that the Christian Science healer asked to be allowed to visit the patient daily. We declined that overture. However, I presume the patient had absent treatment, and in addition received a letter almost every morning. I have a copy of one of these letters which was handed to me by the nurse. Mind you, this patient had only a few weeks to live, was practically in a dying condition, and this is what was sent to her on one particular day.

I want you to-day to settle down really to enjoy to-day. Look at a flower and really enjoy the infinite of flowers. Look at a shadow on the wall and enjoy all its marvellously subtle gradations. Look at a

chair and enjoy all that a chair is. Look at an electric light bulb and enjoy that, all that makes it possible. Look at your nightgown and enjoy all the farflung labour that goes into the production of it for you.

In addition I have one further thing I should like to put on the record before I close. This is information which I have secured from that book. Mr. Fulton, as you remember, declined to disclose to this committee what was the Christian Science method of treatment. I am able to supply this information for the authors state that on page 464 of Mrs. Eddy's manual Mrs. Eddy's treatment is given and consists of the inaudible repetition of the following:—

There is no life, truth, intelligence or substance in matter. All is infinite mind and its infinite manifestation for God is all in all. Spirit is mortal truth; matter is mortal error. Spirit is real and eternal; matter is the unreal and temporal. Spirit is God and man is His image and likeness; hence man is spiritual and not material.

This clearly indicates, therefore, that Christian Science does not rely upon prayer to cure its patients but repeats that formula over and over again for which they make a substantial charge. Thank you, Mr. Chairman, for the opportunity of expressing my views.

Mr. COTE: Would you tell us when and where that book was published from which you quoted during your address?

Hon. Mr. BRUCE: I gave you the names. This book was published by Fleming H. Revell and Company, New York, Chicago, London and Edinburgh. It was printed in the United States of America and is copyrighted in 1925.

Mr. JOHNSTON: Who is the author?

Hon. Mr. BRUCE: The authors are Woodbridge Riley, Ph.D., Frederick W. Peabody, LL.B., and Charles E. Humiston, M.D., Sc.D.

The CHAIRMAN: We will proceed with the bill. We will dispense with the reporter and the press.

Whereupon the further proceedings of the committee were held in camera.

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Canada Social Security, 1944
letter on, 1944

SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 9

THURSDAY, MAY 4, 1944
TUESDAY, MAY 9, 1944
TUESDAY, MAY 16, 1944
THURSDAY, MAY 18, 1944
TUESDAY, MAY 23, 1944
TUESDAY, MAY 30, 1944
THURSDAY, JUNE 1, 1944

WITNESSES:

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
Mr. J. T. Marshall, Chief, Vital Statistics Branch, Dominion Bureau of Statistics;
Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
Mr. R. B. Bryce, Financial Investigator, Department of Finance;
Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;
Mr. A. D. Watson, Chief Actuary, Department of Insurance.

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1944



MINUTES OF PROCEEDINGS

THURSDAY, May 4th, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m., The Chairman, Hon. Cyrus Macmillan presided.

The following members were present:—Messrs. Breithaupt, Bruce, Côté, Gershaw, Johnston (*Bow River*), Kinley, Lalonde, Lockhart, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Nicholson, Veniot, Warren, Wood and Wright.—20.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. J. C. Howes, Research Staff, Bank of Canada;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;

Col. J. R. Munro, Advisory Committee.

The Committee resumed consideration of the draft Health Insurance Bill.

Dr. Heagerty, Mr. Watson and Mr. Gunn were called and examined.

Hon. Mr. Bruce moved,—

That a legal adviser be provided for the Committee.

Motion negatived on division.

Section 4 (1) Was amended by deleting from lines 37 and 38 the words, "from its benefits any person whose income is below any specified amount"

and substituting therefor the words,

"any person ordinarily resident from its benefits, or any specific area in the province."

Adopted as amended.

(2) Adopted.

Section 5—Was amended by inserting in line 2 thereof, after the word "health" the word "services".

Adopted as amended.

Section 6—Adopted.

Section 7 (1) Adopted.

(2) (a) Adopted.

(b) Adopted.

(c) Adopted.

(3) Adopted.

(4) Adopted.

- Section 8 (1) Adopted.
(2) Adopted.
(3) Adopted.

Section 9—Stands.

On motion of Mr. Cote the Committee adjourned at 1.05 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

TUESDAY, May 9, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock. a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Bourget, Breithaupt, Bruce, Cleaver, Coté, Fulford, Gershaw, Gregory, Howden, Hurtubise, Lalonde, Johnston (*Bow River*), Kinley, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, Mayhew, Picard, Nicholson, Shaw, Veniot and Wright.—24.

In attendance were:—

- Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
Mr. A. D. Watson, Chief Actuary, Department of Insurance;
Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;
Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
Mr. R. B. Bryce, Financial Investigator, Department of Finance.

At the request of the Chairman the Hon. Mr. Mackenzie advised the Committee that the Dominion—Provincial Medical Conference would be held in the Senate Railway Committee Room, No. 262, on Wednesday, Thursday and Friday next at 10 o'clock, a.m.; also that a moving picture entitled "The Country Doctor" would be shown in Senate Room No. 368 at 3.00 o'clock, p.m. on Wednesday, May 10th. All members of the Committee were cordially invited to attend the Conference and the moving picture.

The Committee proceeded to further consideration of the Health Insurance Bill.

Dr. Heagerty, Mr. Watson and Mr. Marshall were called and examined.

- Section 9 (1) (a) (b) (c) (d) Adopted.
(2) (a) (b) (c) (d) (e) Adopted.

Section 10—Adopted.

Section 11—(a) (b) (c) (d) Adopted.

Section 12—(1) Adopted.
(2) Adopted.

Section 13—(1) (a) (b) (c) Adopted.
(2) Adopted.
(3) Adopted.

Section 14 stands for reference to the Justice Department.

Section 15 was amended by deleting the word "Division" in the second line thereof and substituting therefor the word "Branch;" also by adding after the word "licensed" in the fourth line the words "in Canada,".

Adopted as amended.

Section 16 was amended by inserting in the first line after the word National, the word "Advisory". Section stands for further consideration.

Section 17 Adopted.

Section 18 Adopted.

On motion of Mr. McGarry the Committee adjourned at 12.55 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

TUESDAY, May 16, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Breithaupt, Bruce, Casselman (*Mrs.*), Claxton, Coté, Fulford, Gershaw, Gregory, Hatfield, Howden, Hurtubise, Mackenzie (*Vancouver Centre*), Macmillan, McCann, McGarry, McIvor, Nicholson, Veniot, Warren, Wood and Wright.—22.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Department Solicitor, Department of Pensions and National Health;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;

Col. J. R. Munro, Advisory Committee.

Hon. Mr. Mackenzie, Minister of Pensions and National Health, read to the Committee the report of the meeting of the Provincial Ministers and Deputy Ministers of Health in Ottawa on May 10th, 11th, and 12th. It was agreed that this report should be printed in the evidence. (*See Appendix "B".*)

The Chairman informed the Committee that he had received seven telegrams from the following persons advising that Mr. J. W. Fulton, who addressed the Committee on behalf of the Christian Scientists, expressed the views of the Christian Scientists in their respective provinces:—

Lt.-Col. T. E. Powers, Halifax, N.S.

E. Aubrey Rideout, Saint John, N.B.

S. Pontoppidan Broby, Montreal, P.Q.

James Perry, Winnipeg, Man.

George C. Palmer, Saskatoon, Sask.

John A. C. Fraser, Calgary, Alberta.

J. Lingen Wood, Vancouver, B.C.

Dr. Heagerty, Mr. Watson, Mr. Gunn, Mr. Bryce and Mr. Brady were called and examined.

The Committee resumed consideration of the draft Health Insurance Bill.

2nd Schedule (1) Adopted

(2) “

(3) “

(4) “

(5) (1) amended by deleting the words “twelve dollars” in the third line thereof and leaving a blank. Adopted as amended.

(2) amended by deleting the words “twelve dollars” in line six thereof and substituting therefor “the amount specified in subsection (1) hereof”. Adopted as amended.

(3) Adopted.

(4) Adopted.

(5) Adopted.

6 (1) Amended by deleting the word “prescribed” in the fifth line thereof. Adopted as amended.

(2) Adopted.

(3) Adopted.

(4) Adopted.

(5) Adopted.

7 (1) (a) (b) (c) (d) (e) Adopted.

(2) Adopted.

(3) Adopted.

8 Adopted.

9 (1) (a) (b) (c) (d) (e) Adopted.

(2) Adopted.

(3) Adopted.

10 (1) Adopted.

(2) (a) (b) (c) (d) (e) Adopted.

(3) Adopted.

(4) Adopted.

11 (1) Adopted.

(2) (a) (b) (c) (d) (e) (f) (g) (h) (i) (j) Adopted.

(3) Adopted.

(4) (a) (b) Adopted.

12 (1) Adopted.

(2) (a) (b) (c) Adopted.

(3) Adopted.

(4) Was amended by deleting all the words after “persons” in the fifth line thereof. Adopted as amended.

(5) (a) (b) (c) (d) (e) (f) (g) (h) Adopted.

(6) Adopted.

13 (1) (a) (b) (c) (d) (e) (f) Adopted.

(2) Adopted.

14 (1) (a) Adopted.

(b) To be revised.

On motion of Mr. Howden the Committee adjourned at 1.00 o'clock p.m., to meet again at the call of the Chair.

J. P. DOYLE.

Clerk of the Committee.

THURSDAY, May 18, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Bourget, Breithaupt, Bruce, Casselman (*Mrs.*), Gershaw, Gregory, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Lalonde, MacKinnon (*Kootenay-East*), Macmillan, McCann, McGarry, McIvor, Nicholson, Warren and Wright.—20.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
 Mr. A. D. Watson, Chief Actuary, Department of Insurance;
 Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
 Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
 Mr. R. B. Bryce, Financial Investigator, Department of Finance;
 Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics.

Hon. Mr. Bruce referred to a letter in the press written by Mr. J. W. Fulton on behalf of the Christian Scientists, in which Mr. Fulton stated that he was not given an opportunity to reply to the statement made by Hon. Mr. Bruce before the Committee on May 2nd. Hon. Mr. Bruce pointed out that on page 233 of the evidence of the Committee he stated that "he would be quite willing to have Mr. Fulton reply". Mr. Fulton was present but did not reply or seek permission to reply. The Chairman declared the incident was now closed.

The Committee resumed consideration of the draft Health Insurance Bill.

Dr. Heagerty, Mr. Brady, Mr. Gunn and Mr. Watson were called and examined.

Second Schedule

Section 14(1) was amended by inserting in line 6 thereof before the word "tuberculosis" the word "pulmonary". Adopted as amended.

(a) Adopted.

(b) (i) was amended by deleting the word "known" from line 2 thereof and substituting therefor the words "recognized by the province". Adopted as amended.

(c) (d) (e) (f) (g) (h) (i) (j) (k) Adopted.

(2) Adopted.

(3) Adopted.

(4) Adopted.

Section 15(1) Adopted.

(2) (a) (b) (c) (d) (e) (f) Adopted.

Section 16 Adopted. (This Section to be brought to the attention of the Reconstruction and Re-establishment Committee, and to the Canadian Medical Procurement Board.)

Section 17(1) (a) Adopted.

(b) Adopted.

(c) Adopted.

Section 17(2) Adopted.

(3) (a) (b) (c) Adopted.

Section 18(1) (a) (b) Adopted.

(2) Adopted.

(3) Adopted.

Section 19(1) Adopted.

(2) Adopted.

(3) Adopted.

(4) Adopted.

(5) Adopted.

(6) Adopted.

(7) Adopted.

(8) Adopted.

Section 20(1) Adopted.

(2) Adopted.

(3) Deleted.

Section 21 Adopted.

Section 22 was amended by deleting from line two thereof the words "the city of" and substituting therefor the words "in such places and"; also from line four delete the words "in that city or elsewhere". Adopted as amended.

Section 23(1) Adopted.

(2) Adopted.

(3) Adopted.

Section 24(1) Adopted.

(2) Adopted.

Section 25 Adopted.

Section 26(1) Adopted.

(2) Adopted.

(3) (a) (b) (c) (d) (e) (f) (g) (h) Adopted.

On motion of Mr. Adamson the Committee adjourned at 1.00 o'clock, p.m. to meet again at the call of the Chair.

J. P. DOYLE,

Clerk of the Committee.

TUESDAY, May 23, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Blanchette, Breithaupt, Bruce, Casselman (Mrs.), Cleaver, Fulford, Gershaw, Gregory, Howden, Hurtubise, Johnston (*Bow River*), Mackenzie (*Vancouver Centre*), Macmillan, McCann, McGarry, McGregor, McIvor, Nicholson, Warren, and Wright—20.

In addendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;

Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission.

Mr. Wright submitted a brief from the State Hospital and Medical League, Regina, Saskatchewan. In accordance with the decision of the Committee on April 20th this brief was ordered printed in the evidence. (*See Appendix "A".*)

The Committee then resumed consideration of the draft Health Insurance Bill.

Second Schedule;

Section 26 (4) Adopted.

(5) Adopted.

(6) Adopted.

(7) Adopted.

(8) Adopted.

(9) Adopted.

Section 27 (1) Adopted.

(2) Adopted.

(3) Adopted.

Section 28 (1) Adopted.

(2) Adopted.

(3) (a) (b) (c) (d) (e) Adopted.

Section 29 (1) Adopted.

(2) Adopted.

(3) Adopted.

(4) Adopted.

(5) Adopted.

Section 30 (1) Adopted.

(2) Adopted.

Section 31 (1) Adopted.

(2) Adopted.

(3) Adopted.

(4) Adopted.

(5) Adopted.

(6) Adopted.

(7) Adopted.

(8) Adopted.

Section 32 (1) Adopted.

(2) (a) (i) Adopted.

(ii) Adopted.

(b) (i) Adopted.

(ii) Adopted.

(iii) Adopted.

(c) (i) Adopted.

(ii) Adopted.

(3) (a) Adopted.

(b) Adopted.

(c) Adopted.

(d) (i) Adopted.

- (ii) Adopted.
- (iii) Adopted.
- (iv) Adopted.
- (4) Adopted.
- (5) Adopted.
- (6) Adopted.
- (7) Adopted.
- Section 33 (1) (a) Adopted.
- (b) Adopted.
- (c) Adopted.
- (2) Adopted.
- (3) Adopted.
- (4) Adopted.
- (5) Adopted.
- (6) Adopted.
- Section 34 Adopted.
- Section 35 Line one was amended to read "If any person wilfully contravenes, fails or neglects". Adopted as amended.
- Section 36 (1) Adopted.
- (2) Adopted.
- Section 37 (1) Adopted.
- (2) Adopted.
- (3) Adopted.
- Section 38 Adopted.
- Section 39 (1) Adopted.
- (2) Adopted.
- (3) Adopted.
- (4) Adopted.
- (5) Adopted.
- Section 40 (1) (a) Adopted.
- (b) Adopted.
- (c) Adopted.
- (d) Adopted.
- (2) The last two lines were deleted and the following substituted therefor; "and any regulation may be varied or revoked by subsequent regulation made in like manner."
- (3) Was amended by deleting the words "laid before" in line five thereof and substituting therefor the words "submitted to." Also by adding after the word Assembly in line five, the words "for ratification." And also by deleting all the words after the word "sits" in lines eight and nine. Adopted as amended.
- Section 41 (1) Adopted.
- (2) Adopted.
- Section 42 Adopted.
- Section 43 Adopted.
- Section 44 Adopted.
- Section 45 Adopted.
- Section 46 Adopted.

Section 47 Adopted.

Section 48 Adopted.

Third Schedule

- I Adopted.
- II Adopted.
- III Adopted.
- IV Adopted.
- V was amended by inserting after the words "of the" in the first line thereof the words "premises, equipment and personnel used for". Adopted as amended.
- VI Adopted.
- VII Adopted.
- VIII Adopted.
- IX Adopted.
- X Adopted.
- XI Adopted.
- XII Adopted.
- XIII Adopted.
- XIV Adopted.
- XV Adopted.
- XVI Adopted.
- XVII Adopted.
- XVIII Adopted.
- XIX Adopted.
- XX Adopted.
- XXI Adopted.
- XXII Adopted.
- XXIII Adopted.

Mr. Graham, M.P., by leave, addressed the Committee stressing the need for research particularly with respect to arthritis. Mr. Howden and Hon. Mr. Bruce stated that considerable progress had already been made in the treatment of this disease. Dr. Heagerty pointed out that provision is made in the draft Bill for research covering all diseases.

Mr. Nicholson wished to have the veterinary surgeons give evidence showing that animal diseases are transmitted to human beings. The Committee decided that the health of animals was a matter under provincial jurisdiction and should not be considered in connection with this Bill.

The Chairman stated that at the next meeting Sections 3, 14 and 16, which were allowed to stand, would be dealt with.

On motion of Mr. McGarry the Committee adjourned at 1.00 o'clock, p.m., to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

TUESDAY, May 30, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Adamson, Blanchette, Bruce, Casselman (Mrs.), Cleaver, Coté, Gershaw, Hatfield, Howden, Johnston (*Bow River*), Lalonde, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Veniot and Warren—20.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
Mr. A. D. Watson, Chief Actuary, Department of Insurance;
Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;
Mr. R. B. Bryce, Financial Investigator, Department of Finance;
Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;
Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;
Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
Mr. J. E. Howes, Research Staff, Bank of Canada.

Dr. Heagerty, Mr. Gunn and Mr. Watson were called and examined.

Section 14 was amended as follows:—

From line 3 thereof delete the words “or of any agreement made thereunder”.

After the word “Law” in line 4 thereof insert the words “from the date of their publication in the *Canada Gazette*.”

After the word “*Gazette*” in line 5 thereof delete all the words. Adopted as amended.

Section 16 (1) was amended by inserting after the word “National” in line 1 thereof, the word “Advisory”.

Mr. Watson submitted a re-draft of Clause 16 (1) which reads as follows:—

There shall be a national Advisory Council on Health Insurance *consisting of* the Director of Health Insurance, who shall be Chairman, the chief administrative officer of Health Insurance of each province which *has in* operation a Health Insurance Act approved by the Governor in Council in accordance with the provisions of Section four of this Act, (*to be appointed with the consent of the province concerned*), *a representative of persons qualified to receive the benefits of health insurance (one from each such province)*, and, in addition, such other persons representative of public health officers, medical practitioners, dental practitioners, pharmacists, hospitals, nurses, industrial workers, employers, agriculturists, rural women and urban women, *and of such other professional groups as may be recognized in the statutory provisions of any province for supplying health insurance benefits*: Provided that at least one member shall be appointed in respect of each of the pro-

fessions, classes and groups aforesaid, and that, in making the said appointments, recognition shall be given to the principle of equal representation in total of the institutions and the professional groups concerned in supplying health insurance benefits, as against the representation of the remaining groups or classes of persons, and to the principle of equality of distribution of members of the Council on a geographical basis throughout Canada.

Mr. Watson was requested to provide copies of this proposed amendment for each member of the Committee for further consideration at the next meeting.

On motion of Mr. McGarry the Committee adjourned at 12.55 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

THURSDAY, June 1st, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:— Messrs. Adamson, Blanchette, Bruce, Casselman (Mrs.), Cleaver, Coté, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Lalonde, MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McGregor, Maybank, Mayhew, Shaw, Veniot, Warren and Wood.
—22.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
Mr. A. D. Watson, Chief Actuary, Department of Finance;
Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;
Mr. R. B. Bryce, Financial Investigator, Department of Finance.

The Committee resumed consideration of Section 16 of the draft Health Insurance Bill.

Dr. Heagerty, Mr. Gunn and Mr. Watson were called and examined.

Section 16 was amended by adding after the word "National" in the first line thereof, the word "Advisory". In line two substitute for the word "comprising" the words "consisting of".

Hon. Mr. Bruce moved:—

"That the Section as amended be adopted."

Mr. Cleaver moved in amendment thereto:—

"That all the words after the word 'persons' in the eighth line of Section 16 be struck out and the following substituted therefor:—'as may be appointed by the Governor in Council as will give parity of representation to the general public receiving health services with those supplying health services'."

Mr. Côté moved in amendment to the amendment:—

“That the word ‘optometrists’ be inserted after the word ‘nurses’ in line ten of Section 16.”

On division the amendment to the amendment was negative.

The Chairman suggested that Mr. Cleaver change his motion to read as follows:—

“That Section 16 be amended by adding after the words ‘Governor in Council’ in line thirteen thereof, the words ‘and representatives of such other groups as may be determined by order of the Lieutenant Governor in Council of any province concerned’.”

And also add after the word “aforesaid” in the last line thereof the words “and that as far as possible there shall be equality of representatives of those qualified to provide and those qualified to receive health insurance benefits.”

Mr. Cleaver agreed to the change and the Section as amended was adopted on division.

The Committee adjourned at 1.05 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

APPENDIX "A"

BRIEF OF THE STATE HOSPITAL AND MEDICAL LEAGUE, REGINA, SASKATCHEWAN

The delegation before you today represent the State Hospital and Medical League, an organization with head Offices in Regina, Sask.

The League consists principally of affiliated bodies such as Homemakers Clubs, Fraternal Societies, Church Organizations, Farm Organizations, Saskatchewan Teacher's Federation, Co-operative Groups, Rural and Urban Municipalities and locals of the State Hospital and Medical League.

For the first quarter of this year the affiliations total over 400. Of these 120 are Rural Municipalities—nearly half of the Rural Municipalities of the province,—six are cities, 24 towns and 56 villages. It will therefore be seen that the State Hospital and Medical League is representative of all sections of the population, both rural and urban.

A lengthy statement on the need for improvement in our medical services would be superfluous. The very existence of your committee is evidence that the need is great. Last year, Feb. 1943, the Saskatchewan Legislature appointed a select special Committee to enquire into the question of health services as well as other social security questions. Fifty-two organizations appeared before the committee; it is interesting to note that this committee in its interim report had this to say on page 7:—

Further in the representations heard and material submitted your Committee found itself confronted with a wide variety of views, opinions, suggestions and proposals. From this confusion however, 4 salient points emerged upon which there appeared to be fairly general agreement. 2 of these are as follows:

1. as to the need for extending health and social services on a wider scale and more equitably and uniformly, throughout the province.
2. regarding the apparent willingness of the people to pay for these extended services.

While many statements have appeared in the press relative to Canada's health standard we will confine this presentation to only 2. The first appeared as an editorial in the Saskatoon *Star-Phoenix* of 25 April and is as follows:—

"Army examinations have shown a dangerously large number of young Canadian whose health is unsatisfactory according to military standards. The record of medical classifications as given recently by Hon. Humphrey Mtichell, Minister of Labor in charge of call-ups under the national mobilization regulations is a challenge to all of the country's health services.

"According to Mr. Mitchell's Statement, 1,015,534 men were called for medical examination and of these slightly more than half, 562,150 were below the standards for front line duty. Here are the number in each group:—

- A Category: Fit for service anywhere, 452,384.
- B Category: Fit for general duty, 123,364.
- C Category: Fit for home service only, 130,316.
- D Category: Temporarily unfit for duty, 23,415.
- E Category: Not fit for army service anywhere, 285,055.

"It must be remembered that these do not represent all the young men in Canada of military age. A large number volunteered for service without waiting

for their military call ups and were accepted in one of the three first categories. Many of those whom the army rejected as volunteers were later called for service and their numbers would swell the proportion of those unfit. But even making allowance for this the record is still a very bad one for a country enjoying the standard of living that Canada has.

"There can be very little reason for a standard of health that results in such a high percentage of rejections. Certainly medical and nutritional science have pointed the way to better living than is represented by these figures. It is evident that the country must begin a definite program to create better health standards than have been enjoyed in the past. Such a program must have a high priority in the postwar world. There are, in fact, many reasons why the program to develop better health should begin immediately, particularly with the boys and girls still in school."

The second statement we quote from Regina *Leader-Post* of 29 Dec., 1942:—

"The dismal picture of the condition of our national health, which Mr. Allan Ross, now in charge at Ottawa, of the production of rations for the Canadian Army and Air Force, painted to an audience of business men in Toronto must increase the general disquietude aroused by earlier statements and revelations on the same subject.

"According to Mr. Ross, out of 50,000 young men who tried to enlist in the active army during one three-month period last year, 20,000 or two out of every five were rejected as medically unfit. Such a prevalence of ill health in the youth of the country, which has enormous productive resources and a huge annual exportable surplus of foodstuffs in itself argues culpable mismanagement of our national affairs."

Then the wastage and expense caused by the inadequacy of the nation's health was suggested by Mr. Ross' further statement that the number of the members of our forces returned from overseas or discharged at home because they could not stand the rigors of training for active service was so large that it was not in the public interest to reveal them. Furthermore Mr. Ross referred to a governmental investigation which has disclosed that out of Canada's 4,000,000 odd children under the age of 16, some 500,000 are undernourished, 250,000 suffer from defective hearing, 77,000 have weak or damaged hearts, 35,000 are mentally deficient, 30,000 are victims of tuberculosis, 1,000 are wholly and 3,800 are partially blind. He also regarded it as deplorable that out of the 26 leading countries of the world, only four had worse records of maternal death rates than Canada and add to this such revelations to whose accuracy Dr. Gordon Jackson, Medical Officer of Health for Toronto, gives unequivocal endorsement should be a source of national humiliation.

To merely say that our Canadian health is at a low ebb is an understatement.

It has been said by representatives of the medical profession that the real problem arises out of the inability of the public to pay for such medical services as are required. The same representatives make this further statement. We quote from the report of the C.M.A. Associations Committee on Economics, 1934:

"It was in the midst of prosperity that the Committee on costs of Medical Care was organized in the United States. It was in January, 1929, that the Royal Commission on State Health Insurance and Maternity Benefits was appointed in B.C. This would seem to mean that, even at the time when money appeared to be most plentiful, this problem was considered as being of major importance. Paying for medical services becomes a problem because illness is not spread equally over the population. It is the unevenness of the burden which creates the problem. It is not the total cost of medical care which gives rise to the difficulty, but the fact that only the percentage of the population which

suffers from illness has to shoulder the total cost. The national medical bill for the U.S.A. in 1929 was \$3,656,000,000 which means an average expenditure, of \$30 per person or \$123 per family. Of this amount 79 per cent was paid direct by individuals. This expenditure is unequally distributed."

The committee on the Costs of Medical Care find:—

No one fact is more clearly demonstrated by the Committee's studies than this one: That the costs of medical care in any one year now fall very unevenly upon different families in the same income and population groups. The heart of the problem, therefore, is the equalizing of the financial impact of sickness.

"The second factor which enters into the problem is that illness is unpredictable as to time of occurrence or severity, or cost and therefore it does not fall into the group of expenses for which an individual or family may budget. Theoretically budgeting might accomplish something but practically we do not budget for the expenditures which cannot be determined in advance.

"Not only are the number of cases of illness unequally distributed, but as illness varies in its severity so does the cost of illness. In a study made by the Metropolitan Life Insurance Co. in co-operation with the committee on costs of medical care, it was found that during a six month period only 198 families out of the 3,281 studied had no expenditure. The total amount spent was \$230,907 an average of \$70 per family, but actually 64 per cent of the total expenditure was made by 20 per cent of the families. This shows that average costs are misleading. It is the actual cost to the individual or family which is of importance. The amount of illness does not vary in ratio to family income but the amount of medical care does. This is particularly noticeable as regards dental care. From this we conclude that the amount of care received is not an indicator of the amount of care required except perhaps in the highest economic groups. The economic condition is frequently a barrier to adequate medical and dental care."

One of the most aggravated factors in the problem is our medical shortage. With less than 8,000 physicians and surgeons in Canada and only 400 in the province of Saskatchewan, the problem has reached the stage of a crisis. Who is to assume responsibility for the tragic consequences in those areas where medical attention cannot be secured? Who is to assume the responsibility for our deplorable situation should a severe epidemic follow this war? These are pertinent questions in the problem which demand immediate attention.

Can we look to the medical profession for the solution? I give you a further quotation from a report of the Canadian Medical Associations Committee on economics 1934, comprising doctors from every province in Canada.

"It seems reasonable that some control should be exercised over the number of students admitted to medical schools.

"To a considerable extent the cost of medical education is borne by the State or private philanthropy. It is a waste of money and of human lives to train men and women for a service which cannot absorb them."

There are conflicting interests contributing to the difficulties of this problem and all concerned can best serve their own interests by seeking the solution that will be permanent. Not a patch work contributory scheme, partly individualist and partly socialized, called "Health Insurance." No man can serve two masters. The true "Best for All" solution will make for permanency. Why tread timidly toward the goal to which obvious factors authentically applied must lead? The better aspirations of mankind are borne of a mighty urge to attain. If we seek the solution unbiased, unafraid and undaunted, we shall find the true solution. Then let us advocate it.

Health Insurance

In nearly every country of the world some form of Fraternal sickness benefits, accident policies, health insurance groups and even health insurance of different types on community and sometimes national bases have been tried. In no country have any of these been satisfactory or free from criticism. They have been inadequate—they have undergone change after change. They have served best by making people think. They have brought us to the point, we hope, where we demand our rights. That is always the proper course. "To thine own self be true and it must follow as the night the day, thou canst not then be false to any man." The 1934 Committee of the C.M.A., in their efforts to laud health insurance say significantly—

In the consideration of Health Insurance as it exists in various countries it should not be compared with an ideal system of medical services but rather judged by comparison with what preceded it. The question is: Do the people receive a better medical service than they did formerly? The Medical profession will naturally ask—Are conditions of medical practice better than they were?

That this very obviously indicates the futility of Health Insurance where all people are to be considered, is certain. There can be no systematic campaign of prevention when only those in a certain income bracket are included. Great pressure is being brought to bear by certain interests in Canada for a ceiling on eligibility for health insurance providing that those whose income is above a certain ceiling will not come under the Dominion-Provincial scheme. Poor man's medicine is not the answer to Canada's health problem.

The United States

Conditions in the U.S. are very similar to those in Canada, as regards health matters.

In 1928 a committee of health experts began a five year investigation of conditions in that country. Approximately half the personnel of the committee were physicians. The committee was not unanimous in the report. In fact three reports were compiled, a majority report and two minority. A summary of these reports is:—

The final report of the committee on the costs of Medical Care is worthy of the most serious consideration, because in large measure, conditions in the U.S.A. are similar to those prevailing in Canada and we should be able to learn a great deal from the five-year study of the problem of the costs of medical care as it existed in the United States.

The committee consisted of 48 members of whom 24 were physicians (13 private practitioners), three dentists, two nurses, six economists and sociologists, three non-medical public health workers, two social workers and 8 representatives of the general public.

As a result of their studies the committee made certain recommendations which may be viewed as plans:

Plan A:

The majority report of the committee (from which nine medical members dissented) is as follows:—

1. The committee emphasizes the value of group organization for service and recommends that, when possible, the medical profession, including physicians, dentists, nurses, pharmacists and other associated personnel be organized into groups, preferably around a hospital, for rendering complete home, office and hospital care including both preventive and curative services.

2. The committee recommends the extension of all basic public health services whether provided by government or non-government agencies so that they will be available to the entire population according to their needs. This extension required, primarily, increased financial support for official health departments and full-time trained health officers whose tenure is dependent only upon professional and administrative competence.

3. The committee recommends that the costs of medical care be placed on a group payment basis through the use of insurance, through the use of taxation, or through the use of both these agencies, Cash benefits, if and when provided should be separate and distinct from medical services.

4. The committee recommends that the study, evaluation, and co-ordination of medical service be considered important functions for every state and local community; that agencies be formed to exercise these functions and that co-ordination of rural with urban services receive special attention.

5. In the field of professional education the committee makes the following recommendations:—

- (a) That the training of physicians give increasing emphasis to the teaching of health and the prevention of disease; that more effective efforts be made to provide trained health officers; that the social aspects of medical practice be given greater attention; that specialties be restricted to those specially qualified; that post-graduate educational opportunities be increased.
- (b) That dental students be given a broader educational background.
- (c) That pharmaceutical education place more stress on the pharmacists' responsibilities and opportunities for public service.
- (d) That nursing education be thoroughly remoulded to provide well-educated and well-qualified registered nurses.
- (e) That less thoroughly trained but competent nursing aides or attendants be provided.
- (f) That adequate training for nurse midwives be provided.
- (g) That opportunities be offered for systematic training of hospital and clinic administrators.

Plan B—Minority Report No. 1:

This report, because it is signed by 9 members of which number 8 are physicians naturally attracts attention because it represents the critical attitude of a part of the medical profession.

The minority find themselves in agreement with the majority as regards public health services and professional education. The minority find themselves in disagreement with the majority on the point of organization. The minority in referring to the Community Medical Centres for organized group practice which is the fundamental recommendation of the majority state:—

There is nothing in experience to show that it is a workable scheme or that it would not contain evils of its own which would be worse than those it is supposed to alleviate.

and

It seems to us an illustration for what is almost an obsession with many people, namely that "organization" can cure most if not all human ills.

and

There is nothing in our own experience nor have we been able to find anything in the committee's studies to lead us to conclude that group practice can furnish better or cheaper medical care than we have at present.

Quoting further from the minority report:—

The plans advocated in the majority report involving groups made up of general practitioners and specialists are theoretically attractive but thoroughly impractical. We are still far away from the time when the general practitioner will be accepted by a group of specialists as a correlator of their work.

We wish to make it clear that the above discussion of group practice does not refer to the association of physicians upon the staffs of hospitals, nor their contact and consultation in clinics.

Groups of specialists as distinctive organizations are very valuable for diagnosing or treating difficult or complicated cases but for 85% of illnesses which make up the family doctor's practice better service can be given by the individual doctor in his own office than in a clinic and at less cost.

In other words the minority have no faith in organization as a solution of the problem and question the value of group practice. The minority (with two dissenting) express disapproval of health insurance but say that if Health Insurance is to be adopted the compulsory plan should be accepted based on European experience. The recommendations of the minority are:—

I

The minority recommend that government competition in the practice of medicine be discontinued and that their activities be restricted (a) to the care of the indigent and of those patients with diseases which can be cared for only in governmental institutions; (b) to the promotion of public health (c) to support of medical departments of the Army and Navy Coast and Goedetic Survey and other government services which cannot because of their nature or location, be served by the general medical profession and (d) to care of veterans suffering from bona fide service connected disabilities and diseases, except in case of T.B. and nervous and mental diseases.

II

The minority recommend that government care of the indigent be expanded with ultimate object of relieving the medical profession of this burden.

III

The minority join with the Committee in recommending that the study, evaluation, and co-ordination of medical service be considered important functions for every state and local community; that agencies be formed to exercise these functions; and that the co-ordination of rural with urban services receive special attention.

IV

The minority recommend that united attempts be made to restore the general practitioner to the central place in medical practice.

V

The minority recommend that the corporate practice of medicine, financed through intermediary agencies, be vigorously and persistently opposed as being economically wasteful, inimical to a continued and high sustained quality of medical care, or unfair exploitation of the medical profession.

VI

The minority recommend that methods be given careful trial which can rightly be fitted into our present institutions and agencies without interfering with the fundamentals of medical practice.

VII

The minority recommend the development by state or county medical societies of plans for medical care.

The principles of any State or county Medical Society plan are:

1. It must be under control of the medical profession (A "Grievance Board" to settle disputes having lay representation, is permissible and desirable).

2. It must guarantee not only nominal but actual free choice of physician.

3. It must include all, or a large majority of the members of the county medical society.

4. The funds must be administered on a non-profit basis.

5. It should provide for direct payment by the patient of certain minimum amount, the common fund providing only that portion beyond the patient's means.

6. It should make adequate provision for community care of indigent.

7. It must be entirely separate from any plan providing for cash benefits.

8. It must not require certification of disability by the physician treating disease or injury.

It will be seen generally that there is a conflict of opinions expressed as between the medical members of the committee and non-medical members. There seems to be a fear (and this has been apparent in all countries) that the medical profession have much to lose if the business management and planning of socialized medicine is to be dominated by non medical people. EXPERIENCE, however, does not indicate that such would be the case. The medical profession in Russia opposed socialized medicine and were so effective in their opposition that Premier Stalin had to come out and definitely take the stand during the terrible typhus epidemic that unless they could unite their forces to kill the typhus louse, the louse would kill socialism in Russia. NOW it is different.

So many controversies have arisen in Canada as regards the merits of the Russian system of socialized medicine and its results that we considered it wise to take advantage of a recent opportunity to make some investigation by correspondence. Through the courtesy of the Soviet Legation at Ottawa and with the kind co-operation of the USSR society for cultural Relations with foreign countries, namely VOKS of Moscow we have learned a great deal.

Just here we want to give you some information we learned from the writings of Prof. N. Propper Chraschenkov. Prof. Chraschenkov in his pamphlets on public health in Russia says: "Everything connected with public health in the USSR is in the hands of the state and is provided for by the state budget. This includes prophylactic and epidemiological establishments (institutes, laboratories, sanitation centres, and the like, medical establishments (hospitals, dispensaries, clinics, sanatoriums, health resorts, maternity homes and the like) children's establishments (nurseries, child health centres, childrens hospitals and sanatoriums) medical science (scientific research institutes, laboratories)

medical school and medical supplies industry." It is further shown by Prof. Chraschenkov that the entire medical staff of the country physicians, nurses, pharmacists, scientists and professors is in the employ of the state. The state provides the physician and the scientist with working conditions most suitable to their activities, placing at their disposal all the latest achievements of medical science and technique."

The State assists the physician to increase his knowledge and skill, by sending him at given intervals to special medical institutes and scientific research establishments so that he can keep in touch with the latest developments in medical science.

There has been a great increase in the number of physicians since the establishment of Soviet power—132,000 in 1937 as against 19,785 in Tsarist Russia in 1913. Today there are approximately two and a half times as many physicians in rural districts as there were before the Revolution. The increase in the number of physicians has been even more striking in the republics of the non-Russian nationalities. In Azerbaijan for example there were 291 physicians before the Revolution, whereas there are 2,840 today; in all of Tajikistan there were only 13 physicians, now there are 372. Public health work proceeds according to definite plan. The establishments staffs, scientific and everyday work of medical institutions and organizations are all planned. At the beginning of every fiscal year, the people's Commissariats of Public Health of the various republics and the local boards of Health determine where hospitals, polyclinics, maternity homes, nurseries, sanatoriums, scientific institutes, medical schools, and the like are needed and how many should be built. At the same time the most important tasks for the coming year are also determined. The fact that all public health work is centrally directed makes possible the proper utilization of all the facilities of the country, the widespread application of the latest achievements in medical science and unified methods of work. The medical establishments and organizations of the Soviet Union are not isolated, insular institutions but are closely interconnected and work according to a common plan of preventive and curative measures.

The entire public health system of the Soviet Union is based on preventative medicine. Efforts and means are directed primarily towards preventing illnesses and safeguarding the population against sickness. The public health system includes numerous and widespread specialized sanitation organizations which engage in work in the field of industrial hygiene and labor protection, housing and municipal sanitation and food hygiene and which combat epidemics. There is an extensive network of scientific research institutes of hygiene, sanitation centres and laboratories which serve as bases for hygienists in their prophylactic work. However, it is not these sanitation organizations alone that concern themselves with prophylactic measures. The entire soviet public health system concerns itself with this work. Even the establishments for treating ill people and therapists base their activities on preventative medicine. For this reason hygiene is a science that is particularly widely taught in all medical schools.

Public organizations of the working people do much to assist the public health institutions. Every city and district Soviet has its board of health. Hospitals and prophylactic institutes have the co-operation of public commissions. Sanitation commissions are organized in apartment houses; collective farms have their sanitary inspectors. The members of these commissions and the inspectors are elected by the local population and go through special training courses in the Hygiene Educational Centres.

These commissions and collective farm inspectors keep a check on the work of medical establishments and assist the latter to carry out prophylactic measures by interesting the public in questions of health protection and making

them conscious of the necessity of observing the rules of hygiene at home and at work. Hygiene Educational Centres were first introduced by the Soviet Government. They supervise all educational work in the field of hygiene in their district. They publish posters and pamphlets, show moving pictures, arrange exhibitions, distribute literature, organize lectures on hygiene, etc.

Soviet public health work has been so efficacious because of the very nature of the social and state system existing in the USSR in which unemployment, destitution and poverty have been permanently done away with on the basis of the abolition of the exploitation of man by man. In a remarkably short period of time, the socialist state has succeeded in raising the material and cultural level of the entire population enormously, thereby laying a firm foundation for successful work in the field of public health.

The reconstruction of industry and agriculture on the basis of modern machine technique has been effected in full accordance with the scientific requirements of industrial hygiene and sanitation. The construction of new cities and the reconstruction of the old ones are also being carried on in conformity with these requirements. Thus, for example, before the Revolution there were 222 cities that had water mains and 33 that had sewer systems, whereas by 1938 there were 384 and 112, respectively. Incidentally, it should be borne in mind that even in those cities of Tsarist Russia where there were water mains and sewer systems, these facilities existed only in the central district of the city, where the wealthier people lived. The water mains, sewer and electric lighting system did not extend to the city outskirts and slums, where the working class population lived.

Slums have long since been wiped out in the cities of the Soviet Union, and the suburbs have been transformed into well-appointed neighbourhoods which in many cases surpass the central districts both as to municipal improvements and architectural layout.

Public utilities are being widely spread in collective farms. Thus the Armenian Soviet Socialist Republic has installed 34 water mains in the rural district, having a gross length of 99.5 miles and serving 53 villages with a population of 108,640. The Daghestan Autonomous Soviet Socialist Republic has constructed 138 water mains in rural districts and an additional 23 are now in the process of construction. The Tartar Autonomous Soviet Socialist Republic has built 38 water mains in the countryside and is building nine more. Prior to the Revolution, these republics did not have a single water main.

The per capita consumption of albumins in the USSR to-day is over 100 grams a day as compared with 35-40 grams in Germany, for instance. Approximately 20,000,000 people avail themselves of the services of public catering in the USSR. Public dining rooms and restaurants have special dietetic tables as well.

At the same time, the wages of the working people are constantly rising. The national payroll has increased from 34,953,000,000 rubles in 1933 to 96,525,000,000 rubles in 1938. The average annual wage of a worker in industry was 1,533 rubles in 1933 and 3,447 rubles in 1938. The Constitution of the USSR guarantees the working people of the USSR the right to free medical services, security in old age, maintenance in the event of loss of working capacity and the right to state protection of the interests of mother and child. All medical service from the first aid to the most intricate surgical operation, is rendered free of charge to the working people of the Soviet Union.

All forms of medical aid, the most up to date methods of diagnosis and treatment, laboratory analyses, X-Rays, physiotherapeutic treatment, hospitalization and sanatorium cures, radiumtherapy, maternity-home services, where methods of painless deliveries have been developed, dental treatment, the provision of orthopedic appliances, etc., are available to the Soviet working people and their families without cost.

The Soviet citizen is given the care of the public health establishment from the very day of birth. As soon as a child is born he is registered in his district child welfare centre. This means that he will be under the constant supervision of a doctor. The mother will be instructed in the care of the child, its regime, diet and proper up-bringing. The child will be vaccinated and inoculated against contagious diseases, and in case of illness provided with medical aid at home or in a children's hospital.

The child welfare centres do not wait until they are applied to for assistance. The doctors and nurses of the centres visit with the child at home, acquaint themselves with his living conditions and advise the parent on the care of the child. In all Tsarist Russia there were only 9 child and maternity welfare centres; to-day, there are 4,385 child and maternity welfare centres in the USSR. Dairy kitchens are attached to these child welfare centres. Babies receive the necessary dairy products here according to the doctor's prescriptions; sick children receive special formulas. Infants from the age of 28 days are accepted in nurseries. The mother may leave her child in the nursery when she goes to work. Here the child is under the supervision of doctors and trained nurses. Besides the regular nurseries, seasonal nurseries are established in rural districts during the farming season.

In 1937 Soviet nurseries (including the seasonal nurseries) accommodated about 4,000,000 children. The nurseries accept children until the age of three and a half. Children up to this age are most susceptible to illnesses and contagious diseases. For this reason the nurseries are under the jurisdiction of the People's Commissariat of Public Health. Children over three and a half years of age are accepted in the kindergartens which are under the jurisdiction of the People's Commissariat of Education.

The number of establishments for the health protection of mother and child is increasing every year. Within the last three years alone, their budget has increased more than three times over and in 1937 reached a sum total of 1,371,000,000 rubles.

Maternity welfare centres of which there are 4,384 in the country afford medical supervision to expectant mothers who register in these centres during their very first months of pregnancy. Here they are given medical advice at government expense.

Working women and all other women employees receive 35 days maternity leave before confinement and 28 days after during which they receive full pay. The maternity centres direct the expectant mother to a maternity home for her confinement.

In 1937 there were over 120,000 beds in lying-in hospitals in the USSR whereas there were only 6,824 in Tsarist Russia. A large number of scientific and practical institutions have been established in the Soviet Union for work in the field of obstetrics.

By decree of the Soviet Union Government in 1936 abortions are forbidden in the Soviet Union with the exception of those cases in which pregnancy endangers life or health of the woman or where there is some danger to the child of inheriting some serious disease from its parents.

Only under Socialism, the system where there is no exploitation, where woman is an equal member of society and where every child is secure and able to look forward to an assured future, since under socialism the constant improvement of the material welfare of all the working people is a law of social development, is it possible to wage a serious struggle against an irresponsible attitude towards the family and family obligations and to combat abortions, by prohibitive legislation as well as by other means.

This is why the Soviet Government bearing in mind the well-known detrimental effects of abortions, met the numerous requests of Soviet working women and enacted such a decree. At the same time the Soviet Government established a system of state benefit to mothers of large families. From June 27, 1936, (the day the decree went into effect) to Jan. 1, 1939, 2,100,000,000 rubles were paid out to mothers of large families by the state. Children receive medical aid in children's polyclinics, dispensaries and hospitals.

Recently the first children's polyclinic in Moscow observed its 20th anniversary. This polyclinic was established on the first anniversary of the Soviet rule. It has a staff of 70 physicians and specialists. From 500 to 600 children are received here daily. It has Roentgen and physiotherapeutic departments, its own laboratory and a sanatorium with 70 beds where children receive treatment during the day, returning to their homes for the night.

In the old days there were no such establishments whatever. It is only under Soviet rule that such establishments were set up in the country. Now every part of the Soviet Union has its children's hospitals and clinics. All children and adolescents undergo an annual medical examination in the spring. At this time children who need to be sent to rest homes and sanatoriums are selected.

In 1938 over 400,000 children and adolescents took cures in children's sanatoriums and about 2,000,000 school children and hundreds of thousands of children of pre-school age spent their summer vacations in health camps.

The care accorded children and adolescents in the Soviet Union is convincingly reflected in labour legislation of the country; the labour of children below the age of 14 is strictly prohibited; minors from 14-16 years of age are allowed to work only four hours a day of light work, and adolescents from the age of 16-18 have a six hour working day. Adolescents are obliged to undergo a thorough physical examination before starting work in order to establish what kind of work can be performed by them in accordance with the state of their health. The enormous expenditures on kindergartens, nurseries, maternity homes, dairy kitchens, sanatoriums, summer camps and rest homes for mother and child have had splendid results.

During the years of Soviet rule, child mortality has declined by over 50 per cent. The chest expansion of Soviet children as compared with the children of Tsarist Russia shows an average increase of one inch, and their height has increased by an average of one and a quarter inches. Thus for example, adolescents employed in the Kolomna Works were from 1 and three-quarters to 2 and a half inches taller and weight $11\frac{1}{2}$ pounds more in 1937 than 1925.

Of great state importance in the USSR is the persistent work done to prevent industrial accidents, since this work is directed towards safeguarding the life and health of the workingman himself, the most valuable asset in the Soviet Union.

A number of institutes which deal specially with industrial accidents and orthopedics have been established in the Soviet Union. These institutes constitute methodological centers both for the study of industrial accidents and means of combatting them, and for training personnel to carry out the latter work.

As a result of the constantly increasing introduction of automatic machinery in industry and compulsory use of safety measures and appliances there has been an enormous decrease in industrial accidents in the USSR. In this connection it is interesting to note that among the most progressive and advanced workers, who participate in the Stakhnov movement and who display high labour productivity, industrial accidents are for the most part less frequent than among the other workers.

The widespread establishment of first aid stations both in factories and collective farms, as well as the fact that people who sustain injuries at work have free access to further treatment, has led to sharp decline in the harmful consequences resulting from industrial accidents.

Health stations in factories and other places of work, first set up under Soviet rule, are extremely important factors in creating healthful labour conditions and combatting industrial accidents. There are 7,631 such stations in the USSR to-day. They render medical aid and carry on health protection work—check up on the sanitary conditions of the given enterprise, introduce measures for decreasing illness and accidents, treat workers who take ill, select people to be sent to health resorts, rest homes and sanatoriums and those in need of special diets in dietetic restaurants. Workers requiring more skilled or special treatment are sent by these stations to district polyclinic or dispensary. The polyclinics are staffed with specialists in all the principal branches of medicines; they have all sorts of medical appliances, provide physiotherapeutic and X-ray treatments and have their own laboratories.

There are $7\frac{1}{2}$ times as many polyclinics in the country since Soviet rule and they accommodate 10 times as many patients. Some urban polyclinics handle between 1,000 and 4,000 patients a day. The Central Railroad Worker's Polyclinic in Moscow has a medical staff of about 1,000 of whom 400 are physicians.

A certain zone in the district where the polyclinic is located is assigned to every therapist in the polyclinic. The physician serves the population of this territory. He receives the people living in the zone assigned him in the polyclinic and visits them at home. But this family physician is in an incomparably better position than the former private practitioner of Tsarist Russia. He has all the latest achievements of medical science at his disposal, X-ray apparatus and laboratories. He can send his patient to any specialist in the polyclinic or call out a specialist to the home of the patient for consultation purposes; he can send the patient for a course of physiotherapeutic treatment and can avail himself of the services of a well trained staff of medical workers. In capitalist Russia T.B. and venereal diseases were extremely widespread among the workers and peasants as a result of the severe exploitation of the working people, unemployment, poverty, the downtrodden and oppressed position of women and insanitary condition of the worker's quarters. The medical profession was powerless to combat these illnesses.

The socialist system has done away with the social conditions that gave rise to these evils. The public health institutions of the Soviet Union with their 5,000 physicians for venereal diseases working in 2,225 medical institutions have succeeded in greatly curtailing venereal infections. Thus, there are only one-tenth as many syphilitic cases in the USSR as there were in pre-revolutionary Russia and new cases of syphilis are extremely rare. The principal source for the spread of syphilitic infection in Tsarist Russia was prostitution (54.7 per cent of all cases). There is no prostitution in the USSR since socialism has wiped out unemployment, poverty and destitution thereby eliminating the economic causes giving rise to prostitution. Thus in 1935 there was not a single case of syphilis among the young men called up to serve in the Red Army from the large cities, towns and collective farms of the principal industrial and agricultural regions of the USSR.

Just as great progress has been made by the Soviet public health institution in the fight against T.B. which has decreased by 83 per cent since Soviet rule was established. In the large cities of the USSR mortality due to T.B. has been reduced to less than half of what it was in pre-revolutionary Russia. Particular attention is devoted to combating T.B. among children. For this purpose not only have children's T.B. sanatoriums been established but special

preventative schools, children's camps and health grounds have been built all over the Soviet Union. There are over one thousand dispensaries for carrying on preventative work among people prone to T.B. and treating T.B. cases, whereas not a single institution of this kind existed in Tsarist Russia.

Urban hospitals have four times as many beds as they had before the Revolution. In 1937 there were 396,000 urban hospital beds as compared with 89,200 in 1913. The republics inhabited by the non-Russian nationalities present a particularly striking picture for here, under Tsarism due to the absence of adequate medical assistance among the population all sorts of charlatans and witch doctors flourished. To-day there are over 3,000 hospital beds in the Turkmen Soviet Socialist Republic whereas formerly there were only 200; in the Uzbek Soviet Socialist Republic the number of hospital beds has increased from 600 to 9,200 and so on.

Besides the quantitative increase it is necessary to note the qualitative aspect of Soviet hospitals, the existence of departments in all principal branches of medicine (therapeutic, surgical, neurological, tuberculosis, children's contagious diseases, gynecological, obstetrical and sometimes ophthalmological departments) the technical facilities (X-ray and light treatment, hydroelectric baths and in many large hospitals mud bath treatment) and special hospital dietary as worked out by the Soviet scientist Prof. Pevsner. The hospitals have highly skilled staffs, besides which they can avail themselves of the consultative services of professors in any branch of medicine, even to the large extent of summoning from cities.

The Dzershinsky Textile Mill is one of the largest factories in Moscow. Before the revolution this enterprise was the property of a certain manufacturer named Prokhorov. Even prior to Soviet rule this factory had something in the nature of a clinic attached to it . . . a few hospital beds, one doctor and a feldsher. Few people could avail themselves of the services of this clinic and even these could not depend on receiving skilled medical aid.

Now the annual budget of the hospital attached to this mill amounts to about one million rubles. There are 100 skilled physicians and professors at the service of the factory workers and the members of their families. Any patient is entitled to receive free medical attention from professors, including specialists of world fame. This hospital has a maternity ward, X-ray departments, a physiological department and a chemical and bacteriological laboratory. The dental department is located in the health centre in the factory itself.

Another example. In Tsarist times there were only two small hospitals with three physicians in the large industrial centre Orekkovo-Xuevo. To-day there are one thousand hospital beds there and fifty physicians. A physician was a rare sight in the villages of Tsarist Russia. Witch doctors and ignorant village midwives held full sway. The rural population could depend only on them for "medical" assistance. To-day district medical centres have been established throughout the countryside. These medical centres have hospitals, clinics, first aid stations, obstetrical departments, collective farm maternity homes, child and maternity welfare centres, nurseries, departments for treatment for prevention of T.B., venereal disease and malaria. Many of these centres have Roentgen and physiotherapeutic apparatus and laboratories. Large hospitals, dispensaries and polyclinics have been built in the central towns of the rural district.

In 1937 there were 175,955 hospital beds in the countryside, whereas in 1913 there were only 49,423. Lying-in hospitals can now accommodate 54,317 women as against 4,611 in the old days. There are 1,626 rural child and maternity welfare centres, whereas there was not a single one before the Revolution. In 1937 there were 370,000 children in the regular nurseries of the countryside, and 3,500,000 in the seasonal nurseries. Urban medical establishments are ever ready to come to the assistance of distant rural settlements in emergency cases by dispatching physicians in airplanes.

The Soviet government takes every measure to strengthen the rural staffs of medical workers; rural physicians receive higher pay, all sorts of material advantages are afforded them, every three years they are sent for a three to four months' course of specialized study in some medical institute, during which time they continue to receive their full pay and an additional allowance.

Increasing numbers of people avail themselves of health treatments. There are hundreds of sanatoriums in Soviet health resorts. In 1937 more than half a million people took sanatorium cures, exclusive of 200,000 clinic patients and the many thousands of people who visited the health resorts on their own and not through some medical establishment.

Over two million people annually spend their vacations in rest homes. In Tsarist Russia health resorts could accomodate only about 3,000 visitors. To-day sanatoriums accomodate 80,000. In the old days, health resorts were only for the privileged rich, the big landowners, merchants, nobles, army officers, government officials and the higher ranks of the clergy. The workingmen had no access to such places. To-day all health resorts are at the service of the working people and their families. Many of the country homes and palaces which formerly belonged to the royal family and the aristocracy have been turned into sanatoriums. A large number of new sanatoriums which are virtual palaces have been constructed.

Besides the establishment of excellent new health resorts, vast improvements have been made in the old health resorts. The Sochi-Matsesta health resort can serve as a good example of how completely the old resorts have been transformed. New, first-class sanatoriums have been opened here. A splendid new bath for balneological treatment has been built, and new sulphur springs have been discovered.

In addition to the famous health resorts of Crimea and the Caucasus which are known all over the world, numerous new health resorts have been established in other parts of the Soviet Union. Every Union and Autonomous Republic has its local balneological and climatotherapeutic health resorts.

The constantly expanding and rapidly increasing scope of public health work in the USSR demands ever larger numbers of workers in this field. The medical schools, where new physicians are trained, are state institutions. The Soviet Union now has 72 independent medical colleges with a student body of over 100,000. Tuition is free and most of the students receive state allowances. Every graduate of any institution of higher schools in the Soviet knows beforehand where he will work. The peoples' Commissars of Public Health of the USSR and the various Union Republics or their assistants, arrange to talk things over with each young physician in order to be able to determine what work he is best suited for and where it would be best to assign him. Of course, the personal interests of each individual are taken into account as well as the requirements of the state. Of the physicians working in the Soviet Union to-day, over 80 per cent are new, having graduated from medical schools during the years of Soviet rule.

The physicians, scientific workers and professors are held in high esteem in the Union. A splendid expression of the respect accorded them is the fact that many medical men and scientists have been elected members of the Supreme Soviets of the Union and Autonomous Republics. **MANY MEDICAL WORKERS HAVE BEEN DECORATED BY THE SOVIET GOVERNMENT FOR DISTINGUISHED SERVICE IN THE FIELD OF SCIENCE AND MEDICAL WORK.**

In the U.S.S.R. medical science is closely bound up with practice. There are 9,600 scientific workers in the 297 Soviet scientific research institutes in the various branches of medicine. On the basis of a wealth of clinical data and extensive research work these workers are able to solve any problem of the utmost importance in the field of medicine.

The work of the late Academician Pavlov and his numerous followers among whom are Academician Orbeli, Professor Razenkov and Academician Speransky is known throughout the world. Academician Burdenko's work in the field of neuro-surgery has also gained wide renown.

Splendid results have been achieved by various theoretical institutes including the Brain Institute, which is headed by Professor Osspov in Leningrade and Professor Sarkissov in Moscow. Outstanding among the numerous scientific experimental and theoretical institutes is the huge all-union Gorky institute on Experimental medicine. The tasks of this institute are to engage in a thorough study of the human organism on the basis of contemporary theories and practice of medical science, to discover new methods of diagnosis, treatment and preventative medicine, based on the latest achievements in the fields of biology, chemistry and physics, and the designing of new equipment for laboratories and clinics. The research work of the institute covers all the theoretical branches of medicine and the branches of other sciences that are of most importance to medicine. It also maintains its own clinics. At present a new building for the VIEM which will cost about 89,000,000 rubles, is in the process of construction.

The Soviet State assigns enormous funds to the development of science. The Soviet public health system, basing its work on the great advances made by science has achieved splendid results in improving the health of the people. It has been able to achieve this on the basis of the general economic and cultural progress made by the country and with the assistance of the masses of the working people. In 1937 the death rate in the USSR was 40 per cent below the death rate in Tsarist Russia in 1913, and in Moscow mortality decreased even more to 50 per cent of the 1913 figure. Child mortality in the USSR was cut in half. The birth rate in the USSR is constantly rising; in 1937 for instance it was 18 per cent higher than in 1936. The natural increase in the population in Moscow more than doubled—from 9.1 per every 1,000 inhabitants in 1913 to 18.6 per 1,000, 1937.

During the period of the third Five Year Plan (1938-42) the people of the Soviet Union will progress even more rapidly along the path to a healthy and joyous life.

The Situation in Canada

The practice of medicine in Canada is very similar to that of the United States. Individual practice with inadequate attention by Departments of Health prevails, with no cost ceilings or supervision other than that imposed by the Medical Associations. Restrictions and lack of facilities in connection with medical education, insufficiently organized clinics for diagnosis or for the use of facilities and agencies known to medical science are common and such facilities as are in existence are not available to many of our doctors: in short a haphazard system which has resulted in 44 per cent of our young men being found unfit for military service.

The average maternal death rate from 1926-1930 was 5.7 and from 1931-1935 it was 5.1. Of the twenty-six leading countries of the world Canada stood fourth from the bottom. The National Committee for mental hygiene (Canada) has this to say:—

According to the last census of 1931, we have a total of 55,513 health workers:—

- 10,031 physicians and surgeons
- 4,039 dentists
- 20,474 graduate nurses
- 11,436 nurses in training
- 6,702 practical nurses
- 869 opticians
- 542 osteopaths and chiropractors
- 1,420 additional health professionals.

According to the standards set up by the Committee on the costs of medical care in the United States, we have a shortage of 4,769 doctors and 6,323 dentists. This shortage is based on the supposition that the whole population would be receiving attention, and that a ratio of one doctor to seven hundred people and one dentist to one thousand people would be required for that purpose.

Under our present system, our ratio is 1 to 1,034 for doctors and 1 to 2,566 for dentists. This is for all Canada. But when we examine the provinces, there is considerable variation in the ratio of health personnel to the people, for example:—

The ratio for doctors varied from 1 doctor for 872 people in Ontario and 1 doctor for 1,578 people in Saskatchewan.

There was a concentration of health personnel in the larger centres of population of Canada. But this 28 per cent was served by 45 per cent of the doctors, 48 per cent of the nurses, and 49 per cent of the dentists.

Health personnel concentrates in the cities because of greater opportunities and greater comfort; and also because better facilities are available—facilities which they have been trained to use, and depend on in practice. Specialists naturally settle in cities, since it is only in the more populous communities that they can expect to earn a living. Consequently the distribution of doctors, dentists and nurses is determined more by opportunities to gain a livelihood than by the actual medical needs of the people.

There were 864 hospitals in Canada with bed accommodation for 85,801 patients, distributed as follows:—

There were—31 hospitals for the tuberculous, with 6,044 beds—58 mental hospitals with 30,516 beds, and 775 general and other hospitals with 49,241 beds. There was a marked variation throughout the country in the bed accommodation, for example,—we find 1 TB bed for 1,187 people in New Brunswick, as compared with 1 for 3,484 in Alberta. In mental hospitals, 1 bed for 293 people for Prince Edward Island, as compared with 1 for 628 in New Brunswick. In general and other hospitals, 1 bed for 135 people in British Columbia as compared with 1 for 489 in Prince Edward Island.

We need at least 3,500 more beds for tuberculosis, of which 3,000 will be required in Quebec and the Maritimes . . . and 500 in Ontario and the Western Provinces.

During the depression period people on relief were given for the first time in Canada medical care, regardless of the ability to pay. The results were that many avoided employment, especially in cases where low wages would not permit a decent standard of living coupled with medical care. Such conditions are deplorable. Little attention has been given to the encouragement of medical education. In fact the tendency has been to allow the medical association to have a large say in medical examinations. The results—a shortage of physicians. This condition aggravated by war conditions has left large areas without doctors, and has placed this country in a dangerous position should a major epidemic follow this war.

In Saskatchewan our municipal medical schemes have demonstrated the feasibility of State Medicine. The Eston Municipal Hospital and medical service is above the average. A 30 bed hospital is maintained with two doctors, eight nurses with splendid services and certain privileges of hospitalization in city hospitals for cases requiring specialists' services. This unit is in good financial condition with a surplus of approximately \$20,000.00. None realize more than those directing municipal schemes, the desirability of municipal units becoming federated into a Provincial scheme. The Canadian situation is such that no province should delay socialized medicine in anticipation of a Federal

Health Insurance scheme. A Federal scheme can only at best be a plan to finance the province as after all medical service is a provincial responsibility and is so provided in the B.N.A. Act. The differences in provinces makes medical service one in which the individual provinces should continue leadership and that Federal responsibility should be to assist financially. If this be sound, then no central government should presume to dictate the details of the Provincial Legislation that will necessarily have to be enacted in conjunction with the Federal Bill. Matters of finance and some regulations to insure that ALL people have equal access to the facilities thus provided with no ceiling of income or exemptions from the plan should be the predominant features of Federal dictation in the Provincial Legislation.

Financing from the Consolidated Revenue of Canada is undoubtedly the most equitable plan that can be suggested. Here is a fund to which the whole population contribute in proportion to their ability to purchase goods or in other words in proportion to their ability to pay.

The urgency of the case is so great that no time should be wasted in trying to impose on the people of Canada, a difficult to understand system of assessments and collections which ultimately would provide many, many equalities, much confusion, and a great array of civil servants, collectors, etc. The machinery already exists for collecting taxes in Canada—why attack a program of worry when the object is to relieve distress?

Worry such as the contributions and assessments in the proposed Federal Draft Bill would of course provide just another handicap in the practice of medicine. Worry is a source of poison and a detriment to the success of medical science.

In the Canadian situation there is involved the fishermen of the Maritimes and the Pacific Coasts whose incomes vary with the seasons and economic conditions. The fruit growers where problems differ from other industries. Then there is industrial and agricultural Ontario, and Quebec with employer and employee difficulties and problems, while we in the West depend upon the weather, the world wheat situation, and a variety of other factors.

Provincial Legislation must be uniform as regards Federal Financial aid and as for including all people because among other reasons all citizens provide the funds. There is some demand for an income ceiling to provide that those having an income above a certain sum, may be left to private practice, the Federal Bill does not preclude this which may be the reason for the tendency in some quarters to urge a contributory system of finance.

To many it is difficult to understand why those who sponsor the Federal Draft Health Insurance Bill persist in the contributory feature. True, the service must be paid for, and undoubtedly this gives rise to the suggestion that an added expense must have an additional form of taxation.

Nothing could be more ridiculous. For instance, should additional household services make necessary more pails of water, does it follow that a new pail must be purchased and a new chore boy engaged? No, certainly not: Our present system of taxation is not lacking in capacity, is not lacking in clerical staff and is not lacking in scope. The consolidated revenue of Canada is contributed largely on a basis of ability to pay, and who will deny that such a system is best for providing the funds to maintain a decent health standard? Why is there that insistence on a contributory system of paying for health insurance with its annoying un-understandable set of assessments, means tests and elaborate returns, coupled with a greatly expanded civil service in the insurance bill? The proposed model Provincial Bill makes it possible that those above a certain income group may not be included in the same scheme, thus reducing the whole project to a relief measure or "poor man's medicine" with insurmountable difficulties in carrying on the work of preventive medicine.

Should the bill become law, then those interests who wish to continue the system of private practice which has failed so miserably, will be in a position to at once begin organizing in each province a demand among the higher income groups to be excluded. If the contributory feature were not included so that all pay through taxation, the higher income groups would rebel and say no, we share in the costs through taxation, and we expect to be included. The recently announced change to a \$12.00 contributory fee instead of \$26.00 only aggravates the situation largely because of the extra income tax with ceilings for the wealthy.

Are we to have complete socialized medicine or just a halfway scheme creating class distinction with preferred service for those who can pay and poor man's medicine for the lower income groups, plus an unwieldy and unwanted system of collections with inspectors and civil servants parading the country coercing the poorer element of the population. That indeed would be regimentation. An all inclusive scheme of medical service financed from the consolidated revenue fund with no income ceiling exemptions is imperative.

The contributory system of finance permits of excluding those in the higher income bracket. The taxation proposal guarantees that all will be included. Preventive medicine cannot be carried on successfully unless all are included. This is quite plain. Epidemics know no class distinction or other boundaries. Imagine the difficulty of preventive work in schools under such a class division. Why patch up the system at one point and break it down at another?

There is little point in discussing Insurance groups in Canada, Co-operative and others because these do not provide for the basic principle of socialized medicine, namely; prevention. These groups are very good for those who can afford to join and for those who are in a sufficiently good state of health to be admitted, and they have been useful educational agencies, but beyond this their benefits are for members.

Saskatchewan

In Saskatchewan necessity has led on to many experiments. The rural municipal schemes in which one-third of our rural municipalities participate have blazed the trail to state medicine. The situation is still serious, however, in many districts and last October 179 delegates from all parts of the provinces gathered in Regina to impress upon our Provincial Government the urgency of the case. We are short of doctors, of hospitals, of facilities and those which we possess are not readily available to the people or the medical profession. Our method of individual practice is wrong. This is demonstrated again and again as unnecessary. Operations are prescribed and modern diagnostic facilities are restricted thus limiting their use and effectiveness. They should be collectivized and operated by specialists for the good of all.

Medical fees are undoubtedly too high and it is regrettable that when price ceilings are the order of the day, no restrictions have been placed upon the cost of medical services. The report of the Federal Advisory Committee on Health Insurance has this to say on page 390—

In a typical rural community with a population of 3,026, a full time physician at a salary of \$4,000 is employed. He provides general medical services, obstetrical care and minor surgery to these people. He acted also as the local health officer. He gave 2,211 office consultations, 1,527 hospital visits, 187 visits to towns and 130 country calls. He attended 58 maternity cases, performed 332 minor surgical operations, as well as 41 emergency major operations. His mileage totalled 2,573.

It is interesting and revealing to make a calculation of the professional services rendered by the physician on the usual fee for service basis. This would work out something like the following:—

2,211 office calls at \$2.00.....	\$ 4,422.00
1,527 hospital visits at \$2.00.....	3,054.00
187 visits to towns at \$3.00.....	561.00
130 country calls at \$3.00.....	390.00
58 maternity calls at \$35.00.....	2,030.00
332 minor surgical operations at \$25.00.....	8,300.00
41 emergency major operations at \$150.00....	6,150.00
	<hr/>
	\$24,907.00

According to the Doctor Whitton Report:—

On the basis of costs outlined in the Heagerty report and in relation to the number of medical practitioners in Canada an average income of \$10,000 per annum in addition to private fees from those in the higher income brackets is provided. If this is to be the average, what then is to be the high water mark? How can this be reconciled with the present average of \$3,142 per annum as indicated in the same report? It is no doubt true that medical accounts are not always paid in full and some allowance should be made. On the other hand there is no justification for unregulated Robin Hood practices.

Supervision of medical fees in a manner fair to both doctor and patient is essential and can best be developed and maintained under State Medicine.

In Saskatchewan, 1940, there were 97 out of 300 rural municipalities in which physicians were paid salaries. In addition 64 towns and villages in the provinces had set up local plans for medical services. The results have been an improvement over the old attempt at private practice and (fee for service).

These districts, however, realize through their experience the necessity for a larger unit and generally favour federating into a provincial scheme and likewise, whatever progress is made on a provincial basis will be all to the good when the Dominion Government has reached a stage where they are prepared to provide a Federal Scheme. Dr. Heagerty, Chairman of the Federal Health Committee, has stated more than once, that Provincial Initiative and action is the only way a satisfactory Federal Scheme can be developed. We refer to Dr. Heagerty's remarks during the hearing of the Canadian Federation of Agriculture's presentation and again in a radio discussion. We quote—

It isn't a matter of preferring, Mr. Callaghan. A National plan is not possible because of the very great difference not only as between provinces but within the provinces themselves.

We also quote from page 550 of proceedings Special Committee on Social Security, June 10, 1943.

We know that you cannot put into Canada one plan from one end of this country to the other that will be satisfactory. You cannot administer from Ottawa one hundred different plans. It must be left to the people themselves to say what kind of plan they want. The cost of administration of a plan from Ottawa would be financially destructive. We do not know what it would cost, but it would cost a great deal more than if the administration and the financing were to come from the province itself. Moreover, we say this. We say that in order to avoid a financial catastrophe, each province should introduce this scheme very slowly into certain areas—rural areas, urban areas, combined rural and urban areas; they should proceed slowly. We do not have to have this whole plan inside of a year. It will take time to implement the plan.

While we agree that Provincial schemes should be proceeded with we also submit that Federal Legislation should not be delayed and that the main features of such legislation should have regard to finance and to making such financial assistance available only on condition that all people be included in those provinces adopting the socialized medicine.

Any legislation designed as the Federal proposals have been designed is certain to be subject to bickering between Dominion and Provincial Governments that will cause endless delay. And then should a decision be arrived at to provide for making the measure effective when say, four or five provinces pass enabling legislation as was the case with the Old Age Pensions Law. There is almost certain to be a privy council hearing engineered by some opposing province because according to B.N.A. act, Medical and Health Services are a provincial responsibility and while the Federal Government might quite legally assist financially we question whether a Federal Commission can carry out the terms of administration to the extent proposed.

In our opinion, the Federal draft bill has been especially designed to curtail the progress of health insurance and socialized medicine. Organized medicine has always everywhere been opposed to socialized medicine and that body has the ear of the government in Canada. There are nine doctors on the Ottawa Committee. An editorial in the Canadian Medical Association Journal has this to say about their strategic position in the working out or the delaying of the health insurance scheme, and we quote:—

“We were fortunate in having as members of Council, Dr. R. E. Wodehouse, Deputy Minister of the Dept. of Pensions & National Health and Dr. J. J. Heagerty, chairman of the Government study committee.” Then further the objective of organized medicine has been set forth by a committee of the C.M.A. as follows:—

In this as in other matters it is the body which has prepared a concrete proposal which may expect this proposal, with modifications, to be accepted and to provide the basic plan for the final scheme. The original basic plan is always difficult to change, hence its vital importance. For this reason alone, the medical profession of Canada should be prepared with such a plan, if they desire to direct the development of health insurance along the lines which to the members appear to be best. This is not a selfish motive because what is best for the medical profession must be best for the public. Passive opposition gets nowhere.

Medical services are now under the legal control of the medical profession and the result is far from satisfactory. First there is the critical shortage of doctors with medical influence permitted in accepting students not only at examination time but for the medical course. This same committee of the medical profession have this to say as regards restricting their own competition:—

It seems reasonable that some control should be exercised over the number of students admitted to medical schools. To a considerable extent, cost of medical education is borne by the state or by private philanthropy. It is a waste of money and human lives to train men and women for a service which cannot absorb them.

There is the unsatisfactory health condition of our people which is generally acknowledged and has been referred to earlier in this brief. We are astounded when we consider these things and also the high cost of medical services—medical fees without supervision or control established by the medical profession—no ceilings imposed making stock in trade of people's misfortunes and setting up fees so ridiculously high that many many people are neglecting their health condition and many suffer or go to an untimely grave. Our office in Regina has received correspondence indicating that the federal draft bill would receive its

first reading in March. The revised draft bears on the cover the words: First Reading March, 1944. We trust this was not designed to mislead people and that none are putting off medical care because of the aforementioned inscription. It seems impossible to believe that the Federal Authorities responsible did not know that there was not the slightest possibility for a first reading in March, 1944, or March 1945. We predict not for several years, and then, perhaps, the Privy Council and nullification.

The Federal Draft Bill is not designed to provide the important features of socialized medicine such as group practice, proper clinical diagnosis and co-operative, economical use of all equipment and facilities known to medical science the value of which has been for years demonstrated by Mayo's and more recently by Kaiser Hospitals.

If further evidence is necessary, that Federal legislation on Health Insurance will be long delayed, let me give you a quotation from *Time* of 13 March, 1944:—

Most of Canada, an increasingly social-minded nation, vigorously approves such legislation in principle. Even so, long delay is certain; when and if Parliament adopts the plan (probably not until war's end) the 9 separate provinces will still have to enact enabling legislation. And some provinces may choose not to participate at all.

And further a press report as follows:—

Comment on the proposals submitted to the committee last week made it clear that health insurance is still very much in the future. It was pointed out that so far as the government is concerned there is no actual bill before the committee, simply departmental suggestions in the form of a bill. When a health insurance bill is formulated it will have to come before the federal and provincial governments before it is introduced in parliament. Last week Prime Minister King indicated that it might not be possible to take up the financial provisions of a health insurance bill at the forthcoming Dominion-Provincial conference.

We now turn to the *Brief of the Canadian Medical Association*.

The attitude of the Canadian Medical Association in their presentation to the Federal Committee on Health Insurance is essential to this thesis; we shall, therefore make some comparisons with the viewpoint of the State Hospital and Medical League:—

1. That in the Provinces where Health Insurance is established, it be administered under an independent Health Insurance Commission, the majority of whom shall be representatives of organized medicine. There should be close co-operation between this commission and the provincial department of Public Health with a view to making full use of preventive services.

The Medical Profession should not be in the majority. Minority rule is alien to democratic principles. Certainly lay people should have the majority representation. We feel that if any small, highly organized group holds out for control of a national scheme it looks like an attempt to maintain special privilege.

2. That a Central Health Insurance Board and Local Insurance Boards be appointed representative of all interested to advise the responsible administrative authority.

This is in line with Democratic policy.

3. That the professional side of Health Insurance Medical Service be the responsibility of the organized medical profession through the appointment of a Central Medical Services Committee and Local Medical Services Committee to consider and advise on all questions affecting the administration of the Medical Benefit.

We believe that the purely professional side of Health Insurance should be under the guidance of the medical profession but do not agree that all questions affecting the administration of the medical benefit should be the responsibility of the medical profession. Here is a point where there is a sharp conflict of opinion. There is nothing under the sun to warrant that the business and administration of any scheme should be controlled by one group. The laity, those who pay for the service, certainly should have much to do with directing the business management of any health service.

4. That the question of establishment of local areas for health insurance administration be left to the decision of the individual province.

We believe that the Health Insurance districts should be decided upon and planned after careful consultation with the people and institutions concerned within the different areas.

5. That the whole province be served by adequate Departments of Public Health organized where possible on the basis of provision of individual health supervision by the General Practitioner.

We believe that this is one of the most important phases of the problem in that it has to do with preventive medicine and shall require the co-operation of all local units of State Hospital & Medical League and other health societies.

6. That Regional Medical Officers act as supervisors and referees, be appointed, paid and controlled by the Commission.

This will be a matter for the commission to decide; such commission should be a representative one.

7. That Medical care for indigents and transient indigents be provided for under the plan, the Government to pay the premiums of the indigents who then receive medical care under exactly the same conditions as other insured persons.

We agree that medical services of the best type should be available to all without discrimination regardless of the ability of the individual to pay.

8. That the plan be compulsory for persons having an annual income below a level which proves to be insufficient to meet the costs of adequate medical care.

We are astonished that a suggestion should be made that the plan be compulsory for any one section of the community. This proposal seems to indicate that those in higher income groups would not be brought under the plan and is probably one of the reasons why the Draft Bill does not make it compulsory for all medical men to be connected with the scheme and a further reason for the contributory features. That any section of the community be left out is unthinkable. Preventive medicine cannot be efficiently administered in such a manner. Epidemics know no salary or financial distinctions and that which is a danger to the whole community should certainly become the responsibility of the whole community. All classes of society should conform to the regulations.

9. That the dependents of insured persons be included in medical benefit.

Agreed.

10. That the only benefit under the plan be the medical benefit.

We in the State Hospital & Medical League are specializing on promoting medical services and we agree that this is a sufficiently large undertaking to occupy the full time and attention of those who will be placed in charge.

11. That the medical benefit be organized as follows.

There then appears under special headings 8 suggestions:—

(a) Every qualified licensed medical practitioner to be eligible to practice under the plan.

We agree, but we certainly do not stop here. Why members of the medical profession wish to avoid being tied up with the health insurance scheme is more than we can understand, especially in view of the often repeated slogan "Chose Your Own Doctor". What choice of doctor will there be provided any large number of medical men decide not to practice under the plan. We are for an all-out health insurance scheme and we see no reason why any section of the community should refrain from coming whole heartedly under the scheme.

B. The insured persons to have freedom of choice of medical practitioner and vice versa.

Obviously this section means that the patient will have the free choice of those medical practitioners who decide to become part of the service.

C. The medical service to be based upon making available to all a general practitioner service for health supervision and the treatment of disease.

D. Additional services to be secured ordinarily through the medical practitioner;

1. (a) Specialist medical service.
- (b) Consultant medical service.
2. Visiting nurse service (in home).
3. Hospital care.
4. Auxiliary services—usually in hospital.
5. Pharmaceutical service.

All these things are very good and very necessary and indispensable, but we are at a loss to understand why the medical profession have not proposed clinics for the larger centres served by specialists with facilities, apparatus, laboratory service, etc., so that errors in diagnosis will be reduced to a minimum. We should have thought that this feature would have been majored by the medical profession. The fact that it has been soft pedalled is an added reason why laymen should have adequate representation on the commission and sufficient control to see that diagnostic services and facilities are adequately provided.

E. Dental service, arranged direct with dentist or upon reference.

This is a detail upon which it should not be difficult to agree.

12. That the insurance fund should receive contributions from the insured, the employer of the insured and the government.

(a) Payment of the premiums of the insured, in certain proportions to be determined, should be made by the employee, employer and government.

(b) Where an insured person has not an employer or where it is not practical for the government to collect from the employer, the government should pay in for that insured person, what would be the employer's share as well as its own share of the premium.

(c) Where the insured is indigent or has been out of work long enough to come without the scope of the provisions of the Act as relating to an insured employee, the government should assume payment of the full premium.

We certainly are not in agreement with the procedure of collecting any portion of the cost of this scheme by direct contributions. The added financial burden, the embarrassment and unsatisfactory situations created throughout the whole country would tend to disrupt the scheme and in our opinion is a needless expense since we already have machinery for making available through taxation the costs of medical services.

13. That the medical practitioners of each province be remunerated according to the method or methods of payment which they select.

14. (a) That the schedule of fees in any health insurance scheme shall be the schedule of fees accepted by the organized profession in the province concerned.

(b) That all schedules of fees be under complete control of the organized medical profession in each province.

15. That the contract salary service be limited to areas with a population insufficient to maintain a general practitioner in the area without additional support from the Insurance Fund.

In answer to this we wish to quote from the Canadian Federation of Agriculture's submission a reply with which we are in complete harmony:—

The average citizen is amazed that any one group should assert such a principle. Nobody proposes to turn over medical services to the control of politicians. Nobody contends, for instance, that a board of aldermen should decide when to operate for appendicitis. The practice of medicine, nursing or dentistry is the responsibility of the professions concerned. But the question of how these services shall be paid for is very much the concern and responsibility of the public.

When John Public scrutinized the schedule of fees as set forth by the Medical Association, he is appalled by the multitude of procedures to which the human body may be subjected, under the advances of medical science. He finds over 300 procedures, varying from \$10 and up, for an ingrowing toenail to \$250 "and up" for a laryngectomy. All of these 300 procedures have no "ceiling"—the sky's the limit supposedly. How can all this be encompassed by a plan to cover all citizens.

This is what is puzzling the public, as well, no doubt, as the unfortunate actual experts.

16. That no economic barrier be imposed between Doctor and Patient.

Just here we want to give you a quotation from the Manchester Guardian as reported in the Leader Post of January 14, 1944, regarding the Medical Associations oft repeated slogan—"Free Choice of Doctor." The quotation is as follows:—

In an address at Cardiff the Minister of Health made no disclosures about his eagerly awaited proposals for a comprehensive national health service but he did give a denial of the "completely misleading tales" that are being told about its principles. His assurance, the Free Choice of Doctor, the personal relationship between Doctor and patient and the clinical freedom of the doctor himself will be preserved, should not have been necessary for there is no inherent threat to these principles in the scheme he is reported to have laid before the medical profession's representative committee. Indeed there is no reason why

a whole time salaried medical service under democratic control should not give the phrase "Free Choice of Doctor" a value and reality which it obviously lacks while private practices are bought and sold, a traffic which could not exist in its present form if a patient allegiance were an act of deliberate choice. It is to be hoped that in view of the minister's statement, his critics will refrain in future from coupling their denunciations of a State medical service with their demands for free choice of doctor, and creating the false impression that the two are incompatible.

17. That the best possible standard of service be required of the professions and that remuneration of the professions be consistent therewith.

Agreed.

18. That provision be made for clinical teaching material for medical schools, that facilities be provided for research work and that time be allowed for post-graduate work.

Agreed.

19. That the plan be actually studied and approved before being adopted and checked at periodic intervals.

Agreed.

20. That some plan be devised for provision of pension for medical practitioners.

Undoubtedly the differences which have arisen in the discussion of health problems can eventually be settled to the satisfaction of the great majority of people and we think ultimately to the satisfaction of all concerned. In other countries, including Russia where similar opposition on the part of the medical profession was evident the difficulty eventually righted itself and our information is that the medical profession in those countries is more pleased with the greater contribution which medical science is able to render under an all-inclusive State System.

We desire here to refer to a public health problem which appears to have been entirely overlooked by your Committee:—

"To those familiar with public health problem as they affect the agriculturist and rural dweller of Western Canada the report of the Advisory Committee on health insurance is disappointing in the extreme. Of late years a great deal of attention has been paid the health of the industrial worker and very good results have been achieved through this effort.

The industrial division of the Health League of Canada has developed a plan endorsed by the Federal Government for the improving of the health of the factory worker that the serious problem of lost time, money and production, because of illness, be reduced to a minimum. It is found that some 50,000 men in Canadian industry are unable to work every day because of sickness. Surveys conducted by industrial hygiene authorities show that time lost through sickness has cost the industrial worker about 135,000 dollars annually while $1\frac{1}{2}$ times this amount is being lost to the employer. It has also been shown that most of this loss is due to preventable diseases.

The efforts of the health league are admirable and no one would deny the factory worker any protection which can be afforded him, but it should certainly be realized that most vocations have their health hazards and a review of the Heagerty report would indicate that agriculture is no exception. The report shows that by far the greatest number of male deaths in Canada was to be found among farmers, and that nearly fifty percent of these deaths were in the age group of 55 to 64.

This finding is significant and makes it very apparent that matters pertaining to public health in rural communities which have been sadly neglected in the past, should receive immediate attention if the agriculturalist is going to receive the same consideration as those in other walks of life. The Heagerty report states: "Generally the health of the people in rural areas does not compare favorably with that in urban districts. One of the greatest needs of the present day is the establishment, maintenance and extension of local health services."

Although health workers, generally, agree that there is no aspect of public health which concerns the agriculturalist more than the control of animal diseases transmissible to man, this phase of disease prevention has not been mentioned and unless those immediately affected assert themselves the matter will no doubt receive but scant attention.

There seems nothing more absurd than to organize so-called Health Units, employ doctors, nurses and sanitary inspectors, and at the same time be content to live in the midst of potential sources of infection—diseased animals. To state that Canadian livestock are particularly healthy and let the matter go at that is no longer acceptable since many of our farm animals suffer from diseases readily transferred to humans and such transference we know does occur quite frequently.

The control of animal diseases in Western Canada has in the past been considered solely from an economic point of view with the result that during the years of low livestock prices infectious diseases were allowed to spread unchecked until now they have become so firmly established that complete eradication is out of the question. It is unfortunate, but true, that some of the diseases referred to are not only of economic importance, but very definitely present a health problem. The public, generally, are prone to consider T.B. as the disease of major importance as far as human health is concerned and if cattle are tested for tuberculosis all is well. This idea has been gained from the fact that publicity has been given T.B. control but the truth of the matter is that many other animal diseases are much more readily transferred to humans than is T.B.

It is perhaps not generally known, for example that influenza of swine is readily carried to humans, in fact, the swine influenza virus is responsible for more cases of human influenza in adults than is the human strain. Swine influenza is very common in western Canada and outbreaks in pigs often appear simultaneously with human epidemics.

Another disease of pigs which has been allowed to run rampant since its recognition in Canada in 1933 is that known as swine erysipelas. Here is a disease which presents a public health problem, the seriousness of which has not yet been recognized. Humans readily become infected with the germ of swine erysipelas through the handling of live animals or when butchering pigs which harbour the germ. The disease in man, erysipelas, may be acute resulting in serious illness or the infection may be localized in the joints producing an acute arthritis which often becomes chronic leaving the affected individual incapacitated for life. Cases of erysipelas have already been recognized in Saskatchewan and no doubt many have gone undiagnosed.

Contagious abortion of cattle is now recognized as a disease of public health importance, man becoming infected either by direct contact or through drinking the milk from diseased cows. The germ responsible for contagious abortion produces in man undulant fever, a disease which may carry on for years, rendering the individual incapable of doing manual labour. These and many other animal diseases are rapidly transferred to those handling unhealthy live stock, presenting an occupational hazard which is real, indeed.

The diseases referred to concern only the agriculturalist because of his intimate association with live stock, but if a public health program is going to benefit the rural dweller generally, we must consider diseases which may be contracted through consumption of essential foods which are produced on farms of western Canada and which in many instances arrive on the market without any form of inspection or control whatsoever.

We are constantly being informed that the first essential to good health is an ample food supply. The nutritionalist lists certain foods as essential to good health, such as milk, meat, bread and so forth but not a word from any source as to the standard of quality essential to insure that these foods are safe, much less, health giving. Milk for example, can be an ideal food or a menace to health depending entirely on its quality. The milk supply in most of the larger centres is safe because of regulations making it imperative that dairy cows be kept in sanitary stables and the cows themselves, be free from T.B. and other transmissible diseases. As a further safeguard all milk is pasteurized before offered for sale. Contrasting with those conditions, the milk supply in most rural areas is far from satisfactory in fact, in some cases, a real health menace. The stables may or may not be suitable for the production of clean milk, and although some towns and villages insist on the testing of cows for T.B. and contagious abortion the majority of the councils take no interest in the matter whatever. Examination of milk sold at rural points in Saskatchewan shows that often it is laden with bacteria and contains much pus that even if it were harmless could never be nutritious. It should be remembered that there are many milk-borne diseases such as T.B. undulant fever, scarlet fever, septic sore throat, and unless drastic steps are taken to improve our rural milk supply, these preventable diseases will continue to appear periodically, causing illness and death.

When we turn our attention to the meat supply of urban and rural centres the same unfair conditions are found to prevail. Government inspected meat is available in all cities while the rural population must be content with that supplied by the local butcher who buys live animals and kills them in the slaughter house at the end of town. The animals may be healthy or may not, but seldom is one condemned. A study of the report of the meat inspection division of the Dominion Health of Animals branch shows that many carcasses are condemned annually by veterinary inspectors and no doubt much of the meat consumed in rural districts would never reach the consumer if inspected by these government officials.

These are the public health problems concerning the rural residents which have a decided bearing on the poor health of those concerned as compared to that of the city dweller who is immune to such hazards. Since this whole matter relates to veterinary science it is unfortunate that the veterinary profession has not been asked to present its views to the Advisory committee on health insurance as without suggestions from such a body little improvement can be expected in the most unsatisfactory conditions which prevail at the present time.

Although it is generally accepted that farming is one of the most healthful of occupations, it is very evident from the Heagerty report that there are health hazards connected with agriculture, resulting in poor health and death rate among farmers quite out of proportion to that among those following other vocations.

The very apparent health hazard confronting the agriculturalist is the close association with animals suffering from bacterial and parasitic diseases which are readily transferred to man. Unfortunately this health hazard is becoming more serious each year because of lack of control of certain animal diseases which are now extremely prevalent throughout western Canada.

It is evident that veterinary science has much more to offer the agriculturist in connection with matters pertaining to public health than has any other profession, and unless veterinary science is represented on the committee of health insurance the agriculturalist will be deprived of the only public health service really of any value to him.

That there is a dearth of qualified veterinary surgeons in the country is well known and steps should be taken immediately to rectify this condition before the health insurance act comes into being, that suitable men might be available to undertake the health work indicated.

Prepaid Medical Care

There are many examples on the North American continent of prepaid medical practice. The great majority of these provide only for those able to pass the medical test and who can pay the fees. Protection and care is commendable but for society as a whole the one underlying principle of national health service or adequate medical care, namely Preventative Medicine, cannot be satisfactorily encompassed.

The efforts of those who have pioneered in the field of prepaid medical care have, however, given rise to improvements and knowledge that has in at least one instance eliminated the health standard qualification. From this achievement has emerged 3 of the 4 dimensions of adequate medical care for all people regardless of the ability of the individual to pay.

THE SHINING EXAMPLE

That it should required the devastation of a great war to bring to our attention such achievements as those now on record at the Kaiser Hospitals in the United States is regrettable but let us nevertheless examine this great institution. It may point the way.

The government's demand for the production of war goods with elderly physically handicapped men and women rejected by the army, a group below par physically, has led to demonstration of medical care providing a beacon light to guide those who pioneer in this great crusade.

Pages of history are adorned with the names of those great ones of earth who have arisen in their generation to hurl forward the torch of progress that the rights of men in the pursuit of happiness may be maintained and extended. People everywhere acknowledge the diligence, capacity and persistence of the Kaiser of Boulder Dam, of Shasta, of Ships, of Cement, of Aircraft, and last and perhaps greatest of all, health services. His teamwork with Dr. Sidney R. Garfield and his associates, Dr. J. W. Neighbor, Dr. C. C. Cutting, Mr. Frank A. Stewart and others, establishing unlimited medical care for a quarter of a million workers and their families at a cost easily within the reach of those concerned, is a shining example to those who pioneer in this great cause. Our reference to the Permanente Foundation Hospital is from first-hand knowledge. Not from hearsay. Not from the enthusiastic journalist but from actual observation and inspection in which the splendid cooperation and assistance of those in charge of the Northern Permanente Hospital, Dr. J. W. Neighbor, medical director and Mr. F. A. Stewart, Superintendent, played a great part.

THE SHIPYARDS AND THE WORKERS

There are 35,000 employees at Vancouver Washington, shipyards. 25 per cent are women, the halt, the lame, the aged, the young, the strong and the "not so strong" make up the remainder. Here we have variety but efficiency, organization, management and above all Good Will, for Kaiser has no labor troubles. The Significance here Should be Pondered. There must be a reason.

The helmeted workers do not even show uniformity in their headgear, a signal provision for quick recognition by their foreman. The mighty swinging cranes, the clanging of steel, the welders' flames, the long string of ships, aircraft carriers being hurried to completion. This is the picture. Men on the job is the vital necessity. Sick men build no ships. Located conveniently in the yards is the first aid station, an integral part of the health service, adequately staffed with doctors, nurses, X-ray and all other modern requirements for rendering most effective service at any and every minute. As we passed through this station we counted 14 workers receiving or being prepared to receive treatment. Equipped for all demands, all except beds, but there stand in readiness a fleet of 5 ambulances ready to convey bed patients to the Northern Permanente Hospital 2 miles distant.

Here in this hospital with its one-third mile of floor space on one level—no stairs, no elevator—unlimited medical care is available to the workers and their families comprising in all 90,000 people.

An inspection of this beautiful, air-conditioned, modern, fully equipped hospital, impresses upon one that no longer is a hospital a place to be dreaded and for the use of the critically ill, but a pleasant, attractive place to take one's early symptoms for diagnosis and for preventative as well as curative medicine.

Obstetric and pediatric care, orthopedics, gynecology, neurology, basal metabolism, physiotherapy, dermatology, surgery, urology, together with X-ray gastrosopes, electrocardiograms, equipment, complete laboratory service, in short the best that is known to medical science is available and on tap at all times coupled with direction and control by skilled specialists in their respective fields, men who are kept at their best, at concert pitch as it were, through adequate practice. Here is an institution that gives medical care commensurate with the needs of the patient. There are no class distinctions. Patients are attended by specialists and nurses who have completed their training. Efficient administration screens the specialist from minor illnesses and accidents. The clinic plan predominates. There is no stinting or false economy. In the words of Dr. Cary A. Johnson of Wilson, Okla.—“I've never in all my experience seen so much and such good care given for so little money. Its contrary to all my experience to see the blood chemistry, the electrocardiograms and X-ray diagnosis so limitless. There is never a question asked about how many. And you know those X-rays run into money.” Dr. Johnson was astounded at the medically motley human material with which Garfield's doctors had to deal. “You understand,” he said, “Down in our outfit we don't take workmen over 45. We give them all a physical examination before they're employed. We weed out the unfit; that lightens our medical load tremendously. It cuts down our cost. And yet our men don't begin to get the complete care these Kaiser workers get.”

At the Northern Permanent Hospital 36 full time doctors and five part time doctors give unlimited care to 90,000 people or to such of them as have need of attention. What is the secret of this efficiency?

1. There is no hesitation on the part of the patients to bring their early symptoms.

2. No lost motion. The admitting department with their doctors and nurses screening process assign the patients to the proper care.

3. Team work: Specialists for their own particular fields.

4. The nursing program is organized to produce maximum results—a two-way speaking system in each ward saves unnecessary steps.

5. Work centres of each district such as maternity section, orthopedic section and etc., group the appropriate staff conveniently to their work.

6. Elimination of financial worry as regards illness. That brings up the question of money. What are the salaries? The management is always proud to give this information. Doctors' average income in the U.S. in 1941 was

\$5,179. Kaiser set his at \$4,800 per year minimum and salaries range all the way from \$4,800 to \$14,000 per annum. Nurses receive \$150 to \$200 per month. The same generous treatment to the staff as to patients.

THE COST

The employees at most of the hospitals pay 50 cents a week, the women 30 cents and children 15 cents. In the latest addition to the Kaiser hospital, that at Vancouver, Wash., the fees are slightly higher but are soon to be reduced. Kaiser plans to reduce the basic 7 cents a day to 5 cents. Undoubtedly this can be done as the present income is sufficient to carry the load and pay off the capital costs at the rate of \$25,000 per month. The hospitals pay themselves off in $2\frac{1}{2}$ to 3 years. No worker has ever been denied the utmost in service; a patient who had a rare form of pneumonia was given treatment that would have cost \$7,000. In four months 600 patients went through one Kaiser hospital for treatment that would have cost from \$500 to \$1,000 each and there were 40 cases that would have cost \$1,000 each. There were five that would have ordinarily cost \$2,000. They were all cared for with no extra charge.

To provide this service on the same all inclusive plan for the Dominion of Canada would cost \$120,000,000. The new principle is that medical, surgical and hospital care must be limitless. There should be no choice between some medical care and complete medical care to the maximum of the science and facilities available. If you modernize medical care you can build and pay off hospitals in a few years time by budgetting in this Dominion for not more than 120,000,000 a year. The Federal Government should help. Grants in aid would be made available for here is both preventive and curative medicine and facilities to administer such care at costs within the reach of our people. Early diagnosis is the great secret of preventive medicine and early diagnosis is assured only if the dollar barrier is removed from between the doctor and patient.

The Kaiser hospitals provide care equal to any in Canada. They are modern, air conditioned, fully equipped, properly planned, adequately staffed with trained nurses, highly qualified specialists, dieticians and with sound business administration. Meals are first class.

These representations are not exaggerated. They are not from hearsay or taken from magazine stories. They are from careful personal investigation. We talked with those who give the service and those who receive it. Due to the courtesy of the management we had every opportunity to satisfy ourselves on all questions. Here is a shining example.

Let us give you a quotation from Dr. Sidney R. Garfields, 1943 Annual Report:—

The rapid growth of our medical organization accounts for many of our problems. Most of our mistakes result from underestimation. We could not know that we would be employing 90,000 men when we started; estimated at first involved half that number. We could not know that the physical condition of the workers would be so far below average. As a result doctors and nurses were too few in number and outpatient space and hospital beds inadequately planned. The resulting strain on our personnel was very great. In face of these deficiencies however, we take a certain amount of pride and satisfaction in realizing that we have performed the most comprehensive job of furnishing medical care in the country. A survey of the accompanying statistics will substantiate that fact. In accomplishing this record we have kept pace with the Kaiser organization in shipbuilding. One can only conjecture as to how much our medical program influenced their production records. How much time was saved? How many lives saved? Statistical studies have been initiated

to answer these questions. Economically the results have been rather amazing. Although working under wartime difficulties with the associated high cost of supplies and high salaries, while receiving only pre-war income (that is, the same income we were receiving per employee five years ago) we have accomplished the following record:

1. We have retired \$500,000 of the debt of \$700,000 incurred in building and equipping our hospitals.

2. We have paid our doctors \$500,000 in income. Salaries range from \$4,800 per year to \$14,000 per year. The average doctor's income in U.S.A. in 1941 was \$5,179.72. Fifty per cent netted less than \$3,912 per year (*Time Magazine*, No. 6, 1943).

3. We have paid our nurses \$494,219.72. Salaries range from \$150 to \$200 for staff nurses.

5. We have treated a group of people definitely below par physically. No physical examinations were possible under union contract but even if permitted we would have been forced to employ practically all of these workers because of the shortage of man-power. Age limits of workers are of no consideration for the duration of the war. Our relations with the medical profession have been poor chiefly because of lack of understanding of our motives, distrust of our financial plan and fear of what it might mean to the economy of private practise. In the past year great strides have been made in securing approval and backing of the leaders of the medical profession. It soon became obvious to all that there could be no real criticism of non-profit organization engaged 100 per cent in war work and doing this work so effectively. We could be no more criticized than the medical organization of the armed services. The mode of rendering service in both is similar—the only difference being that one is government tax operated, the other supported by voluntary contributions by the workers to a non-profit organization. The government has made tremendous demands on us to produce war goods. We have had to accomplish this with the use of elderly and physically handicapped men and women deferred by the army. The medical load has been staggering compared to that of a similar number of men in the army. Considering these factors the medical profession has become more tolerant and has time and again helped us to secure physicians and necessary construction priorities. Acknowledgment is here made to the Procurement and Assignment Service and the Medical Co-ordinating Committee for their assistance. However, it is definitely to be noted that though we have been given thorough approval by most of the medical leaders, all this is tempered with the stamp "Approval For the Duration."

THE BLUE CROSS OR NORTH WEST HOSPITAL SERVICE PLAN

While in Seattle we made investigation of a Hospitalization Plan which is probably the most extensive purely hospitalization program on the North American Continent. Mr. Olson, Superintendent of the Swedish Hospital gave me a generous amount of his time in this connection.

More than 12,000,000 people throughout the nation are now members of the Blue Cross plans in 78 population centres. Out of their few pennies each, paid on a monthly basis, last year over 50 million dollars of hospital bills were paid for these subscribers who required hospital care during that year. In 1942 alone, 144,000 "prepaid babies" greeted the world without a mortgage on their souls.

1. Bed and board and general nursing service in wards (in hospital of your choice) private room may be obtained by paying the difference between the ward and private room rate.

2. All operating room service including anaesthesia.

3. All laboratory services.

4. Drugs and dressings.
5. X-ray service.
6. Maternity service, after 10 months of membership. Removal of tonsils and adenoids in children after 6 months. Adults immediately.
7. Chronic and pre-existing conditions are covered.
8. No age limit.
9. No medical examination necessary to enroll.
10. Hospitalization is furnished in the event of illnesses or surgical cases and for accidents or illnesses away from home.
11. Male adults allowed 111 hospital days, women and children each allowed 21 days per year.

Each plan includes members of the medical profession on its advisory board. Individual doctors say: "subscribers are treated sooner, before their conditions becomes acute or incurable. **FREEDOM FROM WORRY SPEEDS RECOVERY.**"

The American College of Surgeons and many state and local medical societies officially approve BLUE CROSS plans as a protection to individual and national health.

The importance of the physician-patient relationship is recognized by the plan and there is no disruption of personal and professional relationships existing among patients, doctors and hospitals.

Good hospital care costs money. The approved plan subscriber is welcomed at the hospital because his bill is paid promptly by the Plan and there are no credit problems. By use of their Blue Cross cards many subscribers become paying cases, who otherwise would require outside assistance, collection or financing. Those who join the plan help keep the hospital on an even financial keel thereby enabling the hospital to render even more service. For years American Hospitals have housed the finest equipment and best professional skills in the world, but the people who needed care and who couldn't afford to pay for it individually constituted a serious problem. The American Hospital Assoc. studied a way to put necessary hospitalization within reach of all. The Blue Cross Plans solved this problem. Since these Plans originated millions of people are grouped together in communities large and small to ensure themselves of prompt, adequate hospital care. The Blue Cross plans are distinctly an American Institution, an unique combination of individual initiative and social responsibility. They perform a public service without private gain. They prevent a drain upon subscribers savings and stabilize the financial supports of the community's hospitals which provide the services. Through these plans the services of the American hospitals are effectively distributed to meet the health needs of each individual and the entire nation. The success of the Blue Cross Plan in this community as in all others in which it is established depends upon the interest and co-operation of our civic and business leaders and the small monthly subscriptions of members through their employers.

Not new, the Blue Cross Plan is established and working to the advantage of every individual member in 78 cities in areas containing 90 per cent of the population of the U.S.A. A hospital backed contract guarantees and provides necessary hospital service. Every one of the approved Blue Cross units through the U.S. are alike in principle. Transfer of membership from one area to another can be arranged, thereby assuring you of all available service benefits.

The American Hospital Assoc. and American College of Surgeons have approved the Blue Cross plan principle and have established standards for development of non-profit plans. Plans which are organized and operated in accordance with these standards are permitted to identify themselves by use of

the seal of approval of the American Hospital Assoc., superimposed upon a blue cross; hence the name. Approval is granted annually to those Plans subscribing to the following standards:—

1. Community and Professional sponsorship.
2. Non-profit organization.
3. Free choice of hospital and physician.
4. Adequate accounting records.
5. Service guaranteed by hospitals.
6. Adequate statistical data.
7. Sound financial condition.
8. Reasonable growth.
9. Adequate payments to hospitals.
10. Dignified promotion and administration.
11. Separation from hospital finance.
12. Provision of hospital care only.
13. No interference with professional relationships.
14. Sound public policy.

The fees are 75 cents monthly for an individual with a lower monthly fee for each dependent until a maximum fee of \$2 per month is reached. No family regardless of size is required to pay more than \$2 per month. This again demonstrates that the people of Canada can be hospitalized for less than \$50,000,000 and confirms our previous estimate arrived at from the Kaiser experience that complete hospital and medical care including both preventive and curative medicine can be provided for our people at a cost of \$120,000,000. This is slightly more than the sum now proposed by the Federal Committee on Health and Social Security or about the same as the portion to be paid from the consolidated revenue of Canada. Why not simplify the problem of finance by adopting this commonsense method?

GROUP PRACTICE

In these new days of collective impulses, we stand on an eminence, an outgrowth of Material Progress. The higher we climb the further our vision extends. It is those wonders of the future we visualize. In our enquiry let us not be just visionaries. May we be practical as well. If our investigations reveal new methods that challenge some of the old institutions let us view them carefully in the light of reason. The medical profession is not an isolated group who recoil from new methods, although among their numbers, as in any other section of society there are those who retard. It has not been forgotten that Lister's great discoveries in the field of antiseptics were at one time frowned upon by the profession as were the Pasteur discoveries, but where is the medical man who would now uphold that attitude?

The profession has been officially opposed to Socialized Medicine in nearly all countries. It is to the credit of medical men, however, that in those countries where socialized Medicine has been adopted that there has been a marked change in attitude.

No one underestimates the heroic efforts of doctors in the old horse and buggy days and those of our day appreciate the splendid improvements and advances in medical science. Surely no one—and we include the medical profession—will desire to continue an outworn system that denies to many people those modern facilities for treating the sick.

Collective farming is being mooted by some, partly because the one-man farm requires modern equipment that on his limited acreages cannot be used sufficiently to justify the investment.

In a small southern Saskatchewan town there is an X-ray machine locked up in a doctor's back office. It may be used once in a month for minor work (a radiologist is required for important major plates). There is much X-ray equipment in Saskatchewan, but a great dearth of its expert use. Physicians generally cannot afford all the new equipment. The attempt to do so has resulted in high medical fees, prohibitive for many people. Not only does this preclude the use of modern discoveries in a majority of cases but it hampers the work of the doctor as well. How can diagnosis be carried beyond the guesswork stage in those cases requiring laboratory and consultant services when individual practice renders their use prohibitive. We recall the statement of a doctor who, giving an example, explained that a patient called on him for advice. The physician required an X-ray plate, a laboratory examination and several other tests, none of which were available in his office. Had the doctor been in possession of an X-ray he would also have required a radiologist. It was not only the doctor's estimated costs of these services, namely fifty dollars, in this case. The important thing is that too often the diagnosis is not adequately carried out.

Why are so many thousands of patients travelling to the Mayo Clinic? Because of the failure of individual practice, because of the failure to co-operatively apply our medical science. There may be sufficient facilities and an adequate number of specialists, radiologists, neurologists, gynecologists, orthopedic surgeons, dermatologists and so on but under our present system of individual practice, these are not available in their proper field and under correct circumstances.

In private practice the individual doctor is prone to do his own lab. work. His practice may be too small to permit use of technicians or to equip a laboratory properly. Moreover if every doctor were to equip his office and laboratory fully there would be a great waste. The effort at present to accomplish something in this connection has increased medical fees to unreasonable dimensions. Duplication of little used equipment is wasteful, costly and inefficient. Consultations and diagnoses in one fully equipped institution saves the patient's time, saves doctor's time, prevents improperly attempting to deal with disorders in which the doctor may not have specialized and assured the patient of complete diagnosis without his being sufficiently posted in clinical matters to know when he has visited sufficient private specialists.

The private doctor, to be successful must have a pleasing bedside manner and this may not be at all associated with qualifications. That personal relationship between doctor and patient that oft repeated slogan: "Choose your own doctor" has little value when compared to the "Dollars Consideration" making its appearance between doctor and patient and this more especially when the ceilingless prices have spiraled upward by the individual doctor's efforts to operate a complete medical establishment. Socialized Medicine will right this great injustice.

That there is a place for private practise of medicine we do not deny but let such practise be made available to all. Some 50 per cent of all illness is of a minor character and does not require the specialist or clinic. This type of illness is screened out at Mayor's or Kaiser's and other similar Group Practise Centres. The screening out process is no less adaptable to a provincial or federal plan than to those referred to. Efficiency and feasibility of the process is self-evident. Modern, fully equipped hospitals should be provided at strategic points throughout the province. Here group practice would predominate.

Then there is the connecting link—Mobile Clinics and Aeroplane ambulances. In the province of Alberta the Mobile Clinics have demonstrated their effectiveness and efficiency. In 1921 a Dental Clinic proved so successful it was soon extended to include medical and surgical services. National Farm

Radio Forum in a leaflet published December 20 points out that "by 1936 the travelling clinic consisted of a surgeon in charge, an examining physician and anaesthetist, two dentists and four nurses." We quote from the leaflet:—

On the first day of the clinic the two physicians and one dentist are busy examining the children. The parents of children requiring operations are advised and asked to bring the children back the next day. The dentist carries on dental treatments while the nurses take charge of clerical work and necessary organization. On the second day one dentist continues the dental treatment while the second attends to extractions requiring general anaesthesia. The necessary operations are performed on this day also by the surgeons. Patients remain in the improvised hospital ward until the following day when the clinic moves on to the next centre.

Every effort is made to have physicians practising in the community, co-operate with the clinic. They are notified in advance of its arrival and where possible they assist the clinic. Children treated by the clinic are referred to the family doctor for after-treatment when necessary. The clinic has been remarkably successful in its surgical work. No deaths have been recorded following operations. Unfortunately provincial finances have forced restrictions which have limited the extent of the Travelling Clinic's service.

Group practice, clinics, private practice, mobile clinics, aeroplane ambulances are all requisite to complete adequate medical care. They are not expensive. With a well planned service they are an economy. We cannot afford to eliminate any of these things that are worthwhile. We cannot afford to continue the present inadequate haphazard, Robin Hood methods. The results we have recorded herein amply demonstrate the error of such stupidity.

Socialized medicine in Saskatchewan has passed the pioneer stage. Our efforts to date have been extremely successful from the standpoint of those giving the service, and the results obtained. Some have said that the medical profession would not co-operate. We do not share that view. In our experience to date we have no cause for complaint. Our mental institutions although not adequate to properly meet the demand, have certainly registered no complaint on the part of these members of the medical profession who direct the professional side of the institutions nor have difficulties been prominent on the part of those lay people who have had a share in direction and management of our mental hospitals. The same may be said of our cancer and V.D. clinic and other branches of public health service.

It will ever be a matter of pride to the people of Saskatchewan that State Medicine has given us the lowest T.B. death rate in the world. T.B. was, in the early days of the province fast becoming an uncontrollable menace, under the system of private individual practice. It seems that in every crisis whether it be war, epidemics, or pestilence when it reaches the stage of an emergency, excuse and pretense are put to one side and efficiency is ushered in. To wit: T.B. control in Saskatchewan, and now emerging, cancer treatment. Why are we so loathe to adopt self-evident efficient methods? Why must we allow so much in the way of suffering and hardship before we as a people, assert ourselves?

Medical science has now brought forward a new X-ray method of diagnosis for T.B. This same test also portrays many other disorders. If there any common sense to a system which says that one malady shall be dealt with efficiently while all the others are left to a worn-out system that denies the use in many, many cases of the best that medical science has to offer? Is there

any justification for private ownership of medical equipment duplicating the required investment, paid for by patients and only slightly used? Answer this one: Why does not public opinion force into co-operative use and by specialists, if you please, ALL not part here and there but ALL the discoveries of medical science in strategically located centres?

In socialized medicine, society takes a hand by the independent commission method and the examples referred to above show the soundness of this control. A method not circumscribed by sectional dictation, but functioning for efficiency in the interest of all—rich and poor alike.

CONCLUSION

It is difficult to understand why three extensive reports on health in Canada should have almost entirely evaded the question of scarcity of doctors, unequal and unfair distribution of doctors as between urban and rural areas and the undue control by the medical associations over medical examinations with consequent restrictions. It is a glaring travesty on democracy and equality that only those students financially able to meet the cost of medical training should have the opportunity of becoming doctors.

There is probably no other example of a craft, trade or profession being given the privilege of recommending or examining those who will be their future competitors. The principle is wrong and the results seem to have been disastrous in Saskatchewan where even before the war the supply of physicians was far from adequate. In what manner will our governing bodies answer to the people whom they represent should a severe epidemic follow the war as it likely will? Instead of discouraging medical students we should lose no time in opening the way for those whose financial position will not allow them to enter medical college. A properly devised health plan would take care of the repayment of medical fees and part of such necessary advances after graduation.

Medical examinations should be conducted by employees of the State, by medical professors who have reached the top in their profession. Here too is one objective spurring on the initiative of the doctor, for, undoubtedly, medical professors should be retained completely by the State and should be amply rewarded financially and otherwise so that their field would be a desired one and one in which professional competition would play a part.

In this presentation we have not endeavoured to parade the Canadian achievements in Public Health. This has already been overdone by those who have presented reports. We all know that every country has developed to greater or lesser degree in matters of public health. The implication by Dr. Heagerty and other medical men however, that the practice of medicine in America is in advance of other countries is debatable. We do not wish in this report to go into a lengthy section on comparison. We have already quoted extensively from Russian authentic publications received by us direct from Voks Moscow through the courtesy of the Soviet Legation at Ottawa. We should like to quote from the Hungarian Quarterly of (date) on Public Health in that country prior to the war. (date: Autumn 1938.)

The centre of public health work in each village is the health centre: a building varying in size according to the requirements but containing at the least a waiting room and consulting room as far as this is possible, in the capital of each district a larger house is taken, which, in addition to waiting and consulting rooms, contains shower baths and also a flat for the nurse. Baths may be used free of charge by school children. In larger centres consulting rooms for T.B. patients are added and where possible, X-ray appliances. The cost is divided equally between state, country and village. The nurse is in every case paid by the state and receives a salary equivalent to that of a teacher. Cost of the service which is in accordance with the modest standards of the villages, works out at about sixpence per annum per person.

Instead of taking the position taken by medical men of the Federal Civil Service, we should be inclined to offer a frank and open apology to the people of Canada that 44 per cent of our youths were medically unfit for military service in category A, that Canada is only 22 among the countries of the world in maternal deaths, that our medical bill for the Dominion is among the highest in the world and that thousands of mothers have no attention at childbirth and thousands of other people neglect their health because of high cost and shortage of physicians and available facilities, as X-ray laboratory equipment, etc. It is nothing short of ridiculous that in some provinces and Saskatchewan is one, no legislation exists governing specializing in medicine.

It is further very remarkable that in view of the world famous Mayo Clinic's achievements we should have made practically no effort to adopt similar methods of diagnosis and consultation. Results of such institutions afford positive proof that correct methods are not necessarily elaborate and expensive. Net result is actually an economy.

We therefore submit:—

- (1) The present method of providing medical services has not been such as to make the full benefits of curative and preventative medicine available to a large section of our people; and
- (2) The discoveries known to medical science and facilities now in restricted use are not readily accessible to a large section of the medical profession; and
- (3) The advantages of consultations and clinic facilities are not properly and adequately organized so as to guarantee the greatest efficiency in diagnosis; and
- (4) The present practice of medicine on a fee for service basis does not tend to encourage a plan for clinical and consultative diagnosis nor does it encourage preventive medicine and services; and
- (5) Medical Education is available only to those financially able to bear the cost; and
- (6) There is an apparent tendency to restrict the number of students allowed to take medical examinations; and
- (7) The number of doctors available to the Canadian people is far from adequate; and these are unfairly distributed; and
- (8) The planning and administration of medical services is restricted almost solely to one group, namely, the medical profession, thereby eliminating planning and business ability to be found among the laity; and
- (9) The proposed Draft Bill prepared for submission to the House of Commons does not adequately remedy the foregoing weaknesses and proposes unwarranted administration expense in setting up an elaborate assessment and collection department forcing upon the people of this country the burden of an intricate and difficult to comprehend system of returns and reports, and that the provision for excluding from the scheme those above a certain income utterly destroys the possibilities for effective preventive medicine.

As an approach to improving the situation we urge:

- (1) That all available medical services be made accessible to all, regardless of the ability of the patient to pay.
- (2) That Municipal Doctors and hospital schemes be extended with all necessary provincial aid, financial and otherwise to include all municipalities as well as hamlets, villages, towns and cities and unorganized

areas. We ask that in conjunction with the foregoing, well equipped clinics be established for the purpose of diagnosis and specialists for this purpose be trained and plans be laid for federating the municipal schemes into provincial schemes.

- (3) That the Federal Government be requested to provide adequate grants in aid of those provinces establishing a provincial hospital and medical plan, having the approval of the rural municipalities of the province.
 - (4) That Federal authorities continue their efforts to provide an acceptable Federal Bill on Health Services.
 - (5) That Provincial Governments establish medical colleges to train doctors and other health personnel providing scholarships and other assistance for medical students.
 - (6) That the Federal Government make educational grants to the provinces for this purpose.
 - (7) That a provincial department of health take the lead in calling conferences representative of all sections of the population to consider the various health proposals now being placed before the public and especially the Federal Draft Bill.
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In conclusion, we wish to emphasize the fact that we endorse in full and completely support the proposals previously submitted to the Social Security Committee by the Canadian Federation of Agriculture. At the last annual Convention of the State Hospital and Medical League, held in Regina on October 14, 1943, a resolution endorsing the proposals of the Canadian Federation of Agriculture was unanimously approved, by the entire Convention whose members, representing all geographical areas of Saskatchewan, also represented over 400 different Provincial organizations. We are fully convinced that these proposals offer the most logical, the most equitable and the least expensive solution of the problem of providing adequate preventive and curative health services for all the people of Canada. In this we feel that we speak for the great majority of the common people of Saskatchewan and of Canada.

APPENDIX "B"

A conference of Provincial Ministers of Health and their Deputies was held in Ottawa on May 10th, 11th and 12th, 1944, to discuss the subject of health insurance.

The meeting was attended by all Provincial Ministers of Health and their Deputies. There were also in attendance members of the Advisory Committee on Health Insurance and the Finance Committee and a good representation of the Special Committee on Social Security.

All Ministers of Health approved of the principle of health insurance and expressed themselves as being favourable to its early adoption. Some doubt was expressed by some of the Ministers as to their ability to introduce all of the benefits of the Bill at one time or to apply its benefits in all parts of the province at once. The discussion on this phase of the subject was brought to a head by four questions which were referred to the Advisory Committee on Health Insurance and the Finance Committee on Health Insurance for consideration. The questions and answers of these Committees are as follows:—

Questions:

It is our opinion that the Federal legislation dealing with health insurance should be drafted in such a way as to permit:

1. That health insurance benefits be introduced item by item as may be found feasible in any province.
2. That the Federal grants be applied as each item is introduced in any province.
3. That the provinces be permitted to raise the funds in any way they see fit.
4. If it is found from experience that the \$12.00 per capita plus the Federal grant is more than is needed to provide the health insurance services, the provinces be permitted to lower the amount contributed to the Fund.

Answers:

It is the joint opinion of the Advisory Committee on Health Insurance and the Health Insurance Finance Committee:

Questions 1 and 2:

That inasmuch as the draft Health Insurance Bill is now before the Special Committee on Social Security and may not be revised by the Advisory Committee on Health Insurance without authority of that Committee, the question is one for consideration by the Special Committee on Social Security and will be placed before that Committee.

Question 3:

That every individual should be registered and there should be a contribution by and on behalf of everybody. It is realized that there must be a certain amount of flexibility in the method of collection.

Question 4:

That provision has already been made in the draft Health Insurance Bill for this purpose.

It was suggested that some of the grants for public health were inadequate, as follows:—

It was considered that the General Public Health Grant of 25c per capita was too low and it was suggested that this should be increased to 35c per capita.

It was also suggested that the Tuberculosis Grant and the Mental Disease Grant were inadequate and that their acceptance would in some instances cause certain of the provinces financial loss. It was suggested that both grants be raised. The provinces did not suggest the amount by which these grants should be increased.

It was thought that the Venereal Disease Grant was quite adequate and, in fact, one province (Manitoba) expressed the opinion that it might be difficult for the province to expend an equal amount of the grant to that received.

It was suggested that the Professional Training Grant should be raised to \$250,000 and, if necessary, subject to an increase for a period of from five to ten years as needed.

It was thought also that the method in which the Grant for Crippled Children would be divided among the provinces should be specified. Distribution on a per capita basis would be acceptable.

A considerable amount of time was expended on a discussion of the costs. The British Columbia delegates believed that the estimated per capita cost of \$21.60 was high. In order to satisfy the British Columbia members, a meeting of representatives of the Advisory Committee on Health Insurance, the Finance Committee and Deputy Ministers of Health was held on the evening of May 10th. Each item forming the total of \$21.60 was thoroughly discussed and, with the exception of the amount allocated to dentistry which it was thought should be submitted to the Canadian Dental Association for consideration, each item was approved by a motion and passed unanimously.

The report of the committee is as follows:—

The Committee appointed to examine the estimated per capita operational cost figure for Health Insurance in Canada of \$21.60 begs to report as follows:

Item 1. Physicians' Fees.

In view of the information available the Committee is not prepared to recommend any reduction in the per capita of \$9.50 for physicians and consultant services.

Item 2. Hospitalization.

The Committee recommends that the figure of \$3.60 per capita for hospital fees be approved.

Item 3. Nursing.

The Committee recommends that the figure of \$1.75 per capita for Nursing benefits be accepted in lieu of reasonable information to show that the figure should be higher or lower.

Item 4. Medicines and Surgical Appliances.

The Committee recommends that the figure of \$2.55 per capita for medicines and appliances be accepted.

Item 5. Laboratory Services.

The Committee recommends that the per capita figure of 60 cents for Laboratory, X-ray Services, etc., be accepted.

Item 6. Dentistry.

The Committee recommends if the Dental Services are to be limited to children between 3 and 16 years of age the per capita cost figure of \$3.60 for Dentistry should be re-examined and a figure established after discussion with representatives of the Canadian Dental Association.

In regard to the last item, I may say that, although it was clearly intimated that the Bill provided dentistry for everyone in so far as the number of dentists in Canada is available, it seemed difficult to make this clear. The Committee appeared to be under the impression that dentistry was to be limited to children under sixteen years of age and it was on this basis that they carried on their discussion.

However, following the presentation of the report of the committee on costs, it was thought advisable for each of the provinces to study the costs and meet at a later time to discuss them in detail. In this respect it was suggested by the Chairman of the Advisory Committee on Health Insurance that the two experts from British Columbia who had come to Ottawa to deal specifically with costs remain over to discuss costs with the Advisory Committee on Health Insurance. They declined to do so as they claimed they did not have sufficient data with them to support their contention that the estimate of cost was too high.

It was most encouraging to find that there was great unanimity of opinion in regard to the need for health insurance and the advisability of its adoption by all of the provinces at an early moment even though it might not be possible for some of the provinces to apply all of the provisions to all parts of the provinces immediately.

The members expressed appreciation of the action taken by the Dominion in giving leadership in this field.

(Report of meeting of Provincial Ministers and Deputy Minister of Health in Ottawa on May 10-12, 1944.)

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SESSION 1944

CAI XC2 (HOUSE OF COMMONS)

-43571

(SPECIAL COMMITTEE)

(ON)

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 10

THURSDAY, JUNE 22, 1944

WITNESS:

Dr. George F. Davidson, Executive Director, Canadian Welfare Council.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



MINUTES OF PROCEEDINGS

THURSDAY, June 22, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Adamson, Breithaupt, Bruce, Casselman (*Mrs.*), Coté, Fulford, Gershaw, Hatfield, Howden, Hurtubise, Johnston (*Bow River*), Mackenzie (*Vancouver Centre*), Macmillan, McCann, Maybank, Mayhew, Shaw, Warren and Wright—19.

In attendance were:

- Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;
- Mr. A. D. Watson, Chief Actuary, Department of Insurance;
- Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;
- Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;
- Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;
- Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission;
- Mr. J. E. Howes, Research Staff, Bank of Canada.

Mr. Maybank informed the Committee that he had two motions respecting the draft Health Insurance Bill which he desired to move. The Chairman stated that these should be deferred until a later date.

Dr. George F. Davidson, Executive Director, Canadian Welfare Council, was called. He made a presentation to the Committee and was examined.

Dr. Davidson was asked to submit a copy of the letterhead of the Canadian Welfare Council to be printed in the evidence. *See Appendix "A"*. He was also asked to submit a written statement expressing his views as to the measures most urgently needed at present in their order or priority for comparison with Dr. L. C. Marsh's list.

Dr. Heagerty was asked if he wished to question the witness. He did so.

Mr. Johnston moved a vote of thanks to Dr. Davidson for the splendid presentation he made. This was adopted unanimously and tendered to Dr. Davidson by the Chairman.

The Committee adjourned at 12.45 p.m., to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

June 22, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Gentlemen, this morning we will hear from Dr. Davidson of the Canadian Welfare Council.

Mr. MAYBANK: Mr. Chairman, before proceeding to hear the witness may I say that I understood we were to adopt a different course. I understood that you had the idea of hearing Dr. Davidson later. I have not any objection to that.

The CHAIRMAN: Dr. Davidson is here and I think we had better hear him first.

Mr. MAYBANK: I just wanted to say this, that I desire to make two motions in committee. I wanted to know whether it was the expectation—I know it is the hope—that this will be the last meeting of this committee.

The CHAIRMAN: Oh, no.

Mr. MAYBANK: I just want to be sure that the opportunity will be given me to make these motions, and I might indicate the general nature of these motions so that those present will be fully apprised. I have held all along that the matter of dealing with the "irregulars", if I may use that word, should be left in the hands of the provinces and that that should be made very clear in the Act.

The CHAIRMAN: It is, is it not?

Mr. MAYBANK: It is not my opinion that it is; at least not with that clarity which is desirable.

The other motion was to the effect that no person need, if he does not wish, to take the benefits under this Act. Now, that is the general nature of the two motions. I wish to make sure that an opportunity will be granted to me to have this committee pass upon the subject matter of these two points.

The CHAIRMAN: We have completed the consideration of the bill, with the exception of section 3, and we shall have to go back to that later.

Mr. MAYBANK: That is the point, Mr. Chairman; I was a little afraid that it might be considered that we had given consideration to the bill.

The CHAIRMAN: We have completed the consideration of the bill as presented—the draft bill which we have had before us—but we have to consider what we will do with section 3. I assume that before the bill is finally decided upon—before we are instructed to report the bill to the house, any suggestion or motion may be presented.

Mr. MAYBANK: So there will be no possibility of doubt, I will say with all respect that I think we have completed consideration of the sections of the bill. We passed section No. 4 on the distinct understanding that we would come back to it. I believe you will recall the circumstances and that you will agree with me that this matter which I now mention was referred to the advisory committee. There has never been a report back from the advisory committee. I do not care whether a report has come back or not, because for the purpose of cutting into the Gordian knot I drafted a couple of amendments to the Act

myself, and it is these amendments which in due course I wish to propose. In defence of my coming forward with these matters now I wish to say that I understood the idea was that we had completed consideration of the bill, and I say to you, sir, we have not completed consideration of the bill; that what we have done we did with the understanding that we would come back to section 4. As long as that is clear, I do not care when this takes place—when-ever would be the most convenient time.

The CHAIRMAN: We can defer that until later

Mr. MAYBANK: Quite right.

The CHAIRMAN: I shall ask Dr. Davidson to come forward.

Dr. GEORGE F. DAVIDSON, Executive Director, The Canadian Welfare Council, called.

The CHAIRMAN: Will you proceed in your own way, Dr. Davidson.

The WITNESS: Mr. Chairman, and members of the committee, may I say first of all a word in explanation of the circumstances under which I appear here to-day. My organization, the Canadian Welfare Council, has had in mind for some time requesting permission to appear before this Social Security Committee when you got to the stage of discussing the larger and more comprehensive questions of social security, such as those contained in the Marsh report, and we have a committee of our organization at the present time studying proposals and preparing a brief which it is our desire to submit to this committee at a later date when you are in full tilt in your discussions of the social security questions. This appearance of mine to-day, I hope, will not be confused with the later official presentation that our Council has in mind. On this present occasion I have come not as a result of our own request but on your Chairman's invitation and I have been asked to introduce some discussion of provincial welfare services. So that anything I have to say to-day is said more or less as a personal statement by myself without prior consultation with my board, and I would not like it to be thought that my present statement will be taken as a substitute for the brief which my board would like to submit to the committee at a later date.

Mr. MAYBANK: Would Dr. Davidson be good enough to indicate at this stage the composition of the Canadian Welfare Council?

The WITNESS: I will be glad to. The Canadian Welfare Council is a national organization under a private board of governors. It was established in 1920 at the instigation, I believe, of the federal Department of Health—for the purpose of carrying out certain educational and stimulating work in various fields of child health, child welfare and subsequently a wider variety of welfare fields. The president of our organization is Mr. Philip Fisher of Montreal. We have a board of some thirty-six persons comprising outstanding citizens across the country. We have a regional advisory committee comprised of men and women throughout the country. We have, in effect, a fairly large and representative group of citizens who represent both the lay group of citizens and the technical leaders in the various fields of child welfare and health and so on. I wish I had brought a letterhead with me because it contains a list of distinguished Canadian names, but perhaps I may send that to you so as to give you some idea of the type of body we represent.

Mr. MAYBANK: Would it not be a good idea to have that in the report?

The CHAIRMAN: Proceed, doctor.

The WITNESS: With that explanation I come now to what has been suggested as the topic of my remarks this morning. I believe you desire to hear something of the present stage of development of welfare services in Canada. If that is the case may I just say a word in explanation of what I consider to be

included in the term welfare services. The field of welfare services is fairly well distinguished from that of health services, and so I shall largely exclude from my remarks any reference to specific health programs. It is correct, I think, that in certain areas it is difficult to distinguish precisely what is a health service and what is a welfare service, but by and large the distinction is fairly clear and fairly well understood. So there will be little in what I have to say this morning in the nature of comment on health programs.

Welfare services, as I see them, break down largely into two main types of services, and it is about these two main types of services I am going to speak this morning. There are first of all what we might call those *services providing economic assistance*—public assistance programs of various types, unemployment relief as we have known it in the past, poor relief for the relief of unemployables, assistance to the aged in the form of our old age pension legislation, assistance to various types of mothers under the provincial mothers' allowance laws, assistance to the blind in the form of the blind sections of the Old Age Pension Act. All of these types of welfare service are what I lump together under services designed to provide economic assistance, and I think it is clear in all of these types of assistance that the underlying assumption is that the problem for the individual affected or for the family affected is essentially a problem that the provision of cash assistance or economic assistance can solve.

The other type of problem is a different one entirely; it is what we loosely call a social problem. To meet these other social problems, we have different kinds of social services, which I will call for want of a better term at the moment, *the treatment services*. Now, I want you to think with me this morning in terms of those two types of services: to provide economic assistance where cash assistance or provision of material things provides the answer to the problem of the individual family; and the other type is what I call the treatment services, where cash or material help, whether it be in a small amount or a large amount, will never provide the answer to that phase of the social problem. I am thinking in terms of such services as we have on provincial and local levels as these: the protection services in the various local areas or provinces designed to protect children from neglect and cruelty. That problem on the whole is unrelated to the problem of economic need in the family situation, although economic need may affect it to some extent. That is a treatment service where cash for the provision of material help is not the answer to that particular social problem, and where we need some kind of skilled social service to meet that situation. There is that whole field of child protection from cruelty and neglect on the part of parents, the whole field of adoption legislation, the whole field of work with regard to unmarried mothers, the problem of illegitimacy. All these types of programs are necessary in what we call the treatment services as separate clearly from the services where economic assistance is required.

One can go on and illustrate further with reference to juvenile delinquency, juvenile courts, juvenile reform on the provincial or local levels, service in the field of family welfare and domestic relations, mental hygiene services, child guidance, psychiatric clinics—some of those services, I think, are in this borderline area between what I call welfare and the purely health services, because they are related to the problems of social behaviour, social psychology,—and finally with adult crime, jails, penitentiaries, and so on. I could give you a variety of illustrations to make my point clear. Here is the type of program which we include in our general program of welfare services, a type which is clearly distinct from that which I originally mentioned such as old age pensions, mothers' allowances, and so on. This other type is the treatment type of service, because treatment is necessary to bring about improvement in the social condition—a type of treatment for which you cannot substitute material or cash assistance.

Having made that distinction between treatment services and services designed to provide economic assistance, may I say it is not easy in all cases to distinguish clearly between these two groups. These two types are not mutually exclusive; if I may express my personal opinion I think that we have, on the whole, in the development of welfare services in Canada in the past, assumed too readily that in one group of cases all that is necessary is some form of material or economic assistance and that solves the entire problem; in another group of cases what we need is some sort of treatment and we tend to overlook the problem of economic assistance.

From my own experience in provincial services and in examining services of other provincial governments, I could say that our situation with regard to old age pension administration across the country provides an illustration of what I mean in this connection. We have tended to assume that the only thing that the aged person needs to alleviate or remedy his condition is \$20 or \$25 or \$30 a month, and that if you provide that person with a simple cash allowance then all of his other problems will be solved. With all deference I submit that is not the case. There are services required for the aged that I would lump in the treatment section of the welfare services; services of advice and guidance and assistance in finding decent housing accommodation, in handling certain types of personal problems; treatment services which the old age pension recipients should have, as well as the simple provision of some cash assistance. Then we have, on the other hand, services which appear to be purely of a treatment nature where provision of economic assistance may be part of the answer. So it is not possible, even after having suggested to you this distinction between these two types, to assume that they are in all cases mutually exclusive.

With that rough outline of the type of services I am going to talk about, may I go on to remind you of the fact—a fact that you do not need to be reminded of at all—that these services are almost in toto within the sphere of provincial responsibility. Under the provisions of our British North America Act the entire field of social security, with certain minor but important exceptions, is within the sphere of provincial responsibility, and the Rowell-Sirois report pointed that out in a very concise way by making the statement that federal responsibility in the field of social security is an exception to the general rule; provincial responsibility is the main rule with only certain minor exceptions.

Certain of those exceptions have prevailed throughout a very long period of years, covering special services for war veterans, Indians, and special groups of that kind. Certain other of our welfare services, such as unemployment insurance, have been transferred from the provincial to the federal field, as you know, within fairly recent time; but by and large it is still correct to say that the field of welfare services, both in the treatment aspect,—services to children, delinquency services, services in the field of mental hygiene and so on,—and the services providing for economic assistance—those services are still almost entirely within the field of provincial jurisdiction. That means in effect that we can not think in terms of the concept of Canadian-wide welfare services, but we can think in terms of nine different types of provincial welfare patterns. With only one or two exceptions we have to think of these nine patterns rather than in terms of any uniform Canadian patterns. There are very few services to which a person is entitled as a citizen of Canada, as a resident of this country. A mother whose husband dies under certain circumstances governed by residence eligibility, and so on, in British Columbia may be entitled to a mother's allowance if she is a British subject or was born a British subject. If she happens to be an unnaturalized Canadian she is not entitled to an allowance in British Columbia but she is entitled to it in Alberta; and so it varies all across the country until you reach Prince Edward Island where no mother under any

circumstance is entitled to mother's allowance—because Prince Edward Island is the only Canadian province that has not introduced mothers' allowance legislation. You could say therefore that there is no entitlement in so far as Canadian citizenship or so far as Canadian mothers are concerned to this type of social legislation—because it is not uniform across the country, it is non-existent in some parts of the country; and not only that, but these types of assistance vary greatly from an obviously inadequate scale of assistance in some provinces to more generous scales elsewhere affording some degree of adequacy. You get different types of mothers eligible for allowances in different parts of the country. You have in other words nothing that you can call a Canadian welfare service in the field of mothers' allowance; and the same is true by and large of all of our welfare structure. People may be entitled to consideration for certain welfare services, for certain treatment in the welfare field, certain types of economic assistance, as residents of British Columbia, or as residents of Saskatchewan or as residents of the province of Quebec, but at the present time people generally are not entitled to any type of welfare services as citizens of Canada. One of the things I think we are going to have to do some thinking about in the near future is to decide whether we are going to go on with these principles governing the development of our welfare program; or whether we are going to try to think in terms of developing welfare services that apply in some greater measure at least to all the Canadian people.

The next point I would like to make, coming down specifically to our provincial welfare services themselves, is that these services have by their very nature been uneven in their development, altogether apart from the fact that there are nine systems of obviously somewhat disjointed provincial welfare programs each operating within their own field. By virtue of this fact welfare development on a provincial level has been and still is a halting, step by step, process,—very uneven both as to quantity and as to policy among the various provinces; and this statement I would say applies both to those services in the field of economic assistance of what I term the treatment types of services as well. You might say that this is the first and most outstanding characteristic of our present provincial welfare services. I have given you one example already with respect to mothers' allowances. Mothers' allowances have been growing, have been developing in the various provinces since the last war. The province of Manitoba has the distinction of being the first Canadian province to introduce a system of mothers' allowances, having done so in 1917. One by one most of the other provinces of Canada have introduced mothers' allowance programs down through the 1920's; the province of Quebec and the province of New Brunswick have brought in mothers' allowance programs in the 1930's; and now all except one of the Canadian provinces have mothers' allowance legislation, with wide varieties, of course, because of the nature of such legislation and the various scales of assistance and the recognition of different categories and different types of mothers and conditions of eligibility and of residence. In other words there is no clear recognition that we can all agree to of certain principles which would apply uniformly across the country to the assistance that we as Canadians want to provide to mothers whose bread-winner has been lost from the picture.

That same slow, step by step growth, that same unevenness of services in terms of quality and quantity applies I think through all of our provincial picture. Take our child welfare services as another case in point,—where you have for over fifty years a child protection act passed in the province of Ontario to provide for the creation of a provincial child welfare superintendent, local children's aid societies, to provide a statutory basis upon which action can be taken against parents in the interests of neglected children, and those children can be removed and provided for under safer auspices;

that child protection act in the province of Ontario paved the way, as it were, and all the other provinces have adopted similar legislation. You have now, only within the last month, the ninth Canadian province, the province of Quebec adopting for the first time in its history a comprehensive child protection act. It took a long time to get this network of services all across the country, and it will take an even greater length of time to get rid of all the inevitable unevenness in quality of service as between the various provinces. And, it would be surprising if the child protection legislation of the province of Quebec which is less than a month old and where the machinery has not been established at all as yet,—it would be very surprising if that service in a year or two years would reach a state of development comparable with similar services in the province of Ontario, or even reach that in a longer period of time. You have that unevenness of pattern inevitable in this picture. You have it throughout, as I say, all of the welfare services. You had it even in our relief services of the depression years. And I think all of the members here will agree with me when I say that you have it even in the old age assistance field, where you have varying scales of assistance in the various provinces; although there may be some measure of uniformity achieved here by federal participation in the program. Even at the present time some unevenness has developed as a result of the recent increases that have been made, loosening up of some of the provisions of our old age pensions arrangement which is now in effect. As it is now the maximum old age pension allowance under the federal arrangement is \$25 instead of \$20 a month—but some of the provinces have gone on beyond that and they are providing in addition to that maximum a further \$5 per month as a provincial wartime cost of living bonus. Three of the provinces have done that. Another province has paid \$3 supplementary allowance over and above that \$25 maximum; and five of the provinces have still stuck to the \$25 maximum itself. So that even there where you have a certain measure of uniformity achieved through the fact of federal participation you still have variations as between what an aged recipient of Canada is entitled to through having lived in the province of Alberta for example, and what an aged resident of Canada would be entitled to if he were living in the province of New Brunswick. It seems very clear to me from our experience in old age pensions, for example, and our relief services during the depression years that the federal government can do much through its participation in these welfare programs to see that a greater measure of uniformity is achieved. By reason of what has been done we have achieved a certain measure of uniformity, although it is by no means complete, and a greater measure of consistency is certainly desirable and I suggest that that can best come under federal leadership through participation in these public assistance and social welfare plans operated at the provincial level. I think the old age pension program and the relief services illustrate that; they show that some of the inconsistencies and lack of uniformity that exist can be adjusted and ironed out through federal participation. This tendency to have federal participation result in a measure of equalization of service is also demonstrated, in reverse, by the fact that when the federal authority withdrew from the relief picture in April of 1941 these unevennesses of service began to creep in again in a much more accentuated form than they had developed during the depression years. Now you have certain provinces where there are no provincial relief services at all on the level of basic relief.

The second characteristic I would mention about provincial services—and I offer this as no criticism of the provincial services at all, because I have been a provincial civil servant myself, and to that extent I have been partly responsible for some of these defects or weaknesses that are to be found in our provincial services—I would say that the second characteristic of provincial services to date is that they have been hind-sighted rather than foresighted;

they have dealt with problems that have emerged as being emergent problems; and I suggest that it was quite natural that they should have been dealt with only when they had emerged in a fairly critical form. They have concentrated on remedial correctives on the palliative side of the problem rather than on the preventive side.

I am sure that anyone who has had experience in the health field would readily see the comparison between the trend of our services in the health field and the trend of our services in the welfare field. We have been concentrating our attention on the remedial rather than the preventive aspect. We have thought in the field of economic assistance of such things as relief, Mothers' Allowances, and Old Age Pensions. We have not up to the present time thought clearly or in any concentrated form about the question of social insurance. We have thought in the health field in terms of providing medical and hospital services and only recently have we been thinking more and more of preventing the onset of illness through the development of preventive and public health programs. Even our child protection services, of which we know many of the provinces are rather proud, have up to the present time concentrated much more on the extreme cases which require the actual protection of children from the more glaring types of neglect and cruelty rather than expanding into the field of prevention of neglect and working with a family before the situation reaches a critical stage. For another illustration let us take our mental hospitals in respect to which we are spending millions of dollars in custody and treatment programs and tens of thousands of dollars only in the development of preventive services. I say that again not in any spirit of criticism of the provinces but simply to try to give you the picture of what I conceive to be one of the main characteristics of our provincial welfare services at the present time.

I think it is clear that the provinces are, both with respect to financial assistance and treatment, giving a greater measure of recognition to the value of prevention and the preventive aspect of child welfare and to the preventive aspect of health and to the preventive aspect of these other problems, so that they may be able to reduce their commitments on the curative and remedial services at a later time. It seems to me that that leads to a conclusion which I state merely as a personal one, that of the federal government's opportunity for constructive leadership, which as I see it centres around the stimulation of these preventive services in both the health and welfare fields which will be designed to cut down our public commitments on last-stage types of treatment and relief at a later date.

The third characteristic of our provincial services is one which I think is a natural result of the manner of the development of the services and that is lack of integration between the various programs operating within each province itself. Take one illustration: we have in a number of the Canadian provinces a variety of services of a public assistance nature, operating throughout the entire province. We have old age assistance for one. We have unemployment assistance and poor relief for another; and we have child welfare for a third; and if you like, mothers' allowance for a fourth; and in some of the provinces we have at the present time a high degree of departmentalization as between these various services to the point where the provincial department itself may have two, three or even four separate field staffs each one concentrating upon a specialized aspect of the welfare program. In other words, a mothers' allowance program is developed and a staff operates investigating cases and attesting the application of recipients of mothers' allowances and for that purpose the provinces appoint a staff of mothers' allowance investigators—and usually by reason of the fact that women are presumed to be principally concerned, they appoint a woman investigator because they understand the problems of women better than men do. You would have therefore a staff of mothers' allowance visitors spread throughout the province on that particular job. Then you have

the formation of the old age pensions branch, and for some reason that I have not been able to understand most of the provinces seem to think that old age pension problems are all purely financial, purely concerned with estimating the economic need, with interjecting all the many intricate rules and regulations which centre around the question of eligibility for old age pensions; and your typical provincial authority seems to think that what you need for old age pensions is a staff of male investigators, and a staff of male investigators is appointed for that purpose.

Through the development of child welfare services in the province, your province may develop a special staff to carry out its child welfare service. Then, again, in connection with your unemployment services you frequently find that a separate staff is developed to carry out that work throughout the province. On the other hand, in some of the provinces, they are beginning to conceive of all of these welfare services on a related basis grouping them as one entire problem; and within the last few years some very significant developments in a number of the provinces have become apparent whereby they are endeavouring to make a generalized approach to the problem and they are endeavouring to see that this question of field service is put in the hands of qualified people; that is the key to the whole problem, the use of well qualified people who will take a certain district of their province and be responsible for all the provincial welfare services in that one relatively small district. You get then the possibility of the integration of welfare services as between one type of program and another type of program.

The fourth characteristic, and one which I would like to call to your attention with particular emphasis today because I see a very serious problem arising in connection with this matter; the fourth characteristic of our provincial services is this: because of the very fact that the provincial services are based on the principle of local responsibility, either provincial or municipal, eligibility for service or benefit is also based on this question of local eligibility. The province in effect says that by the provisions of the British North America Act we are responsible for giving welfare services to our people; we are therefore going to take great care to define in our own terms who our people are; and in delegating some of these social service questions to the municipalities it is only natural to expect that the municipalities themselves are going to be very rigid and very technical as to who are residents of a municipality eligible for any contemplated social assistance.

The result is that because we have been faced with this principle of local residence and responsibility for service that we have built what to my mind is a very serious tangle of walls around our respective local areas and our respective provinces, each province and each local area making an effort to protect itself against unwanted individuals from outside of their respective immediate local areas; with the result that greatly needed assistance is denied to people who might conceivably be in need of public assistance and yet might not be genuinely residents of a local community.

We had in the province that I know best, British Columbia, up until 1936 or 1937 not less than eleven different types of social legislation in which we included special provisions saying that only persons with a certain amount of residence—three years, six years or a year or whatever it might be—were eligible for a certain type of social assistance. Each of these different sets of residence regulations was different. There was no consistency within the province even; nor is there any consistency as between the provinces of Canada even yet, as between what is required on the basis of residence to establish eligibility for assistance from the local or provincial authorities. There are municipalities in this country where you can lose your residence by moving out and staying overnight and it would take you seven years to get your residence back again. And you have this problem of lost residence which was serious enough during the

depression years but which I submit is going to be far more serious in the post-war period when you begin to think of how many—not thousands or hundreds of thousands but how many millions of Canadians have moved their place of residence during these war years. Now I hope and all of you I am sure hope that none of these people are going to require any type of social assistance when this war is over; but I am afraid some of them are. Some of them are going to require hospitalization and under some of our provincial laws even if a person is able to pay his hospital bill often times there is involved the question of determining the place of residence of the person in order to collect certain per capita charges which may come back on a local municipality; and other welfare services also involve the question of residence.

All of our social legislation is at present tied up with this question of residence. May I read to you one paragraph of a book called "England's Road to Social Security" written by Karl de Schweinitz, in which he quotes from a pamphlet written by William Hay, an Englishman, back in 1751:

It is certain that the obligation on each parish to maintain its own poor, and in consequence of that, a district interest, are the roots from which every evil relating to the poor hath sprung; and which must ever grow up, till they are eradicated. Every parish is in a state of expensive war with all the rest of the nation: regards the poor of all other places as aliens; and cares not what becomes of them if it can but banish them from its own society. No good therefore is ever to be expected till parochial interest and settlements are destroyed; till the poor are taken out of the hands of the overseers and put under the management of persons wiser and more disinterested; and till they be set to work on a national or at least a Provincial fund to arise from benefactions and the labour of the poor as far as they will go; and what more is wanting to be levelled by an equal tax.

We have here a pretty clear statement with regard to certain conditions that existed in England two centuries ago because of this insistence on the principle of a narrow area of local responsibility. We took that over by and large in our Canadian set-up, our Canadian provincial legislation, and we still have it; and while a number of provinces have made some effort, legislative and otherwise, to bring about a certain measure of uniformity, we still are restricting very seriously the effectiveness of the various types of our social legislation by these residence restrictions. These are understandable, because each province feels it has to protect itself against invasion from outside by indigent persons. I know that we felt particularly worried about that in British Columbia during the depression years when we had the transient movement of single unemployed and we had to move in unsocial ways to protect ourselves in the narrow provincial sense and render a dis-service to Canadian citizens in need, when we did that.

I would like to urge most strongly that one of the important problems we face in our welfare services at the present time is the solution of this problem of residence. I do not know whether it has been drawn to the attention of this committee in any serious form before. I do not know in detail what responsibility this committee or the federal government could take because again it is a problem of provincial jurisdiction; but this I know—of this I am convinced—that if we allow our present tangled residence laws to continue in the post-war period we are going to involve ourselves in some pretty serious problems, when we begin to deny to decent, respectable, Canadian citizens who have been called away from their local place of residence to serve in a war factory or in the armed forces—when we let them go back to their local communities and then deny them the right to certain social service benefits because they do not happen to be a resident of a certain municipality or a certain provincial jurisdiction.

I should like to mention one final characteristic that I see developing now, so far as our provincial welfare services are concerned. I have personally been very much heartened in the last year and a half to see what I believe is a very significant trend on the part of our provincial authorities to establish sound and well integrated provincial welfare departments. Provincial welfare services have been, ever since their inception, a stepchild of some provincial government department. They may be attached to the Ministry of Highways or to the Ministry of Health or the Ministry of Labour. They are tucked in somewhere. Part of them may be in the Attorney General's department and part in the Department of Education. There is no consistency among the provinces, no recognition of the fact that the welfare services are services which are important enough to justify recognition with a ministry of their own or a ministry in which recognition is given through the name of the ministry to the existence of social welfare problems and services.

I think it is very significant that within the last year—during the last six months in fact—no less than three of the Canadian provinces have set up ministries of social welfare and no less than three of the Canadian provinces have had within the last year over-all surveys or studies made of their entire network of provincial welfare services. It is, I may say, the first time that provincial governments have taken an over-all look at their own social services—have recognized the existence and the entity of social services. That to me is an indication that the provincial authorities are now taking a look at their own provincial programs, setting their own houses in order, are admitting welfare services to the status of respectability and significance by giving them at least partial cabinet rank; and they are preparing the way so that they may, when the time comes, sit down with the federal authority and allocate on a clear cut basis the relative responsibility which will be assumed by the new federal department and by these newly developed provincial departments. If we can achieve that degree of clarity in our division of functions between the federal authority in the welfare field and the provincial authority, and if we can encourage the provincial authorities to integrate their welfare services into a single department, or a single department in conjunction with the health services with which they are most closely related, we will begin to be in a position where we can look at our welfare service program as a whole and integrate it through generalized field service staffs as has been done in some provinces, and build up a well qualified personnel in those provinces, which is one of the most tragic lacks at the present time. In that way if we can solve, in addition to making these changes—if we can solve the problem of residence as a restricting factor in the provision of these welfare services we will then be able to say that co-operatively we are truly developing a pattern of Canadian welfare services, where one province can benefit not only from its own experience but from the experience of adjacent provinces, and where the result will be a much better degree of efficiency and social service effectiveness for all the people who are in need of these services in all parts of Canada.

Finally, Mr. Chairman, may I say that I have deliberately made my remarks general because I understood there might be a question period after I have finished, and I wanted to build a fairly broad platform upon which to launch a discussion. If I can cope with any questions, I shall be glad to do so.

The CHAIRMAN: Doctor, to complete the record will you please send in a copy of the letterhead?

The WITNESS: Yes.

Hon. Mr. MACKENZIE: Knowing the provincial situation as you do in every province of Canada with reference to social legislation and welfare legislation, and knowing the program now before parliament and before this committee,

what would you say would be required for an integrated and concerted structure of national social welfare as between that and what has been done by the provinces?

The WITNESS: Before you came in, Mr. Mackenzie, I made it quite clear to the committee that this was rather a premature appearance on my part. Our Canadian Welfare Council has asked for the privilege of sending in a brief. Having said that may I remind those who are here that about a year ago we sent out from our office a little pamphlet called "The Future Development of Canadian Social Services." That pamphlet went to every member of parliament. It was an expression of my own personal views as to the requirements of the Canadian situation. If you will look in whatever places you file such documents, you will find that little pamphlet there. I think it sets out some of the essentials, as I see them, in terms of that necessary integration. I would add that one of the first requirements is the matter which I have mentioned, provincial counterparts of the proposed federal department of health and welfare, so that we will have two negotiating bodies who can look at the field as a whole instead of having to deal, as now, with a provincial department of labour or of education or the attorney general's department with respect to a wide variety of different services.

The CHAIRMAN: Would you care to comment on the progress in Canada as compared with the progress in other countries as regards these matters? I suppose there is no ideal system.

The WITNESS: No, my personal opinion—and this is purely personal opinion—is that up to the time the Beveridge report made its appearance, and subsequently the Marsh report—my personal view at that time frankly was that Canada was going to find itself at the tail end of the procession of the English speaking world. We are not doing our part so far as social welfare services are concerned. I think we are behind New Zealand. I think those of you who heard Mr. Walter Nash speak before this committee—

The CHAIRMAN: The reconstruction committee.

The WITNESS: Yes, before the reconstruction committee, can appreciate something of what I have in mind when I say that. I think we have a relatively undeveloped situation in terms of over-all planning of welfare services, as compared with England, where the problem is much simpler because it is not a federal state. I think, we are definitely behind the United States in terms of our social welfare development, because of the fact that they have moved ahead much farther in their social service legislation since 1935 than we have in Canada. When I say that you begin to see what is the present place of Canada among the English speaking nations of the world. That, as I say, is a purely personal opinion, and I have expressed the hope in addresses I have made across the line with regard to the Canadian welfare field that while we may at the present time be lagging behind the procession, this federal program that is now under consideration may mean, at least, that we have started faster to implement some of our post-war social service programs than either England or the United States will have done. I think there is a fair chance, if we carry through along the lines of what we have under consideration at the present time, that we will at least narrow the gap between ourselves and the United States and England and New Zealand; because as I see it at the present time there is little to indicate at the moment that early action can be expected on the Beveridge report in Great Britain and there is nothing to indicate at the moment that any action can be expected on the National Resources Planning Board report across the line. One or two bills have gone into Congress which are designed to deal with certain phases of that problem, and my information is that those bills are likely to get a pretty rough reception and are not likely to go very far. If we can move forward in parliament on the program which we have under consideration,

I think we will have begun to catch up with the procession; but I would never suggest that even is accomplishing what we have before us we will have reached the stage of development that Great Britain or the United States or New Zealand have reached, because I think they are very considerably ahead of us at the present time.

Mr. HOWDEN: Assuming that we adopted the program that is before us at the present time, are you disposed to think it leaves very much still to be desired with regard to the matter of social service?

The WITNESS: I am. The problems we have before us—

The CHAIRMAN: Will you outline the main points?

The WITNESS: Let us outline what you have before you at the present time. You have before you at the present time presumably—I am speaking in terms of the committee—

HON. MR. MACKENZIE: Both the house and the committee.

THE WITNESS: All I have heard as being before you at the present time is health insurance, most definitely, children's or family allowances, most definitely, old age insurance in what I can only think of as being a very indefinite way, because apart from one or two general pronouncements that I have seen in *Hansard* there seems as yet to have been no concrete coming to grips with that problem. Fourthly, and this is a very significant and important thing, there is the announcement of the appointment or setting up of a federal department of health and welfare. When we compare that with what Great Britain already has—or what is proposed in the Beveridge report or in the Marsh report—it still leaves, obviously, some very definite gaps in the total program. We have no disability insurance, we have no cash benefits for health insurance under consideration at the present time, as I understand the picture. We have no survivors' insurance. I think of those three things in particular as being obvious items which are mentioned specifically in the Marsh report and which are not as yet tangibly under consideration by this committee or the house. However, many of these items are already in existence in other countries of the world, in terms of social insurance measures. In addition to all the above, we have to face, as a country, rather than as a federal parliament, the question of filling in the gaps which still exist in our provincial welfare services. I have mentioned the fact that in some provinces services exist and in other provinces services do not exist. That, perhaps, is not a federal problem, but it is a problem of the Canadian people if they are going to develop an adequate welfare program.

Finally, and equally important, in my opinion, there is the problem of strengthening and improving our existing social services so that they can achieve some degree of adequacy, which is not the case, in my frank personal opinion, in all provincial jurisdictions at the present time. I prefer not to speak too specifically about this, because I do not think it would be fair to mention names of any provinces, but the provinces themselves know from the contacts we have made with them that we have some very definite opinions as to their varying standards of service; that certain of the provincial welfare programs are of a high calibre and certain others are quite the reverse. So there is the problem of levelling up and improving the adequacy of the services that we nominally have on paper at present. I think we have still a good deal to do and that we will be some time in doing it.

Mrs. CASSELMAN: May I ask this question? One of the difficulties experienced in introducing legislation of this kind is the question of personnel. Would the trained personnel be available now or in the near future?

The WITNESS: The answer is most decidedly no. I do not like to burden this committee with the tragic problem of social work personnel resources in Canada at the present time, but it is one of the most pathetic conditions we

meet when we are considering as we are considering and as the government is considering, large scale measures of social development which cannot be carried out by just the ordinary run of the mill people without any qualifications or any training of any kind. I am sure that these positions have to be filled by competent personnel, professionally trained. I have talked of treatment services, and I mean that. They are treatment services, I submit, in just as professional a sense as there are treatment services in the medical field, and we have to have properly qualified people if we are going to entrust some of these intimate and delicate social and personal problems to the handling of our government machinery.

I speak of this with some feeling, because I do not mind admitting that we have been trying for a year and a half—our Council, with the Canadian Association of social workers and the Canadian Schools of Social Work—to get some federal assistance for our schools of social work and for recruiting and training programs; but I cannot see that we are much further ahead than when we started. I know this, it is going to be the number one problem when it comes to implementing any social welfare program; and one of the most important factors in the success or failure of the present suggested legislation is that there shall be adequate realization of the need to use qualified people whom you will need when you want to put this legislation into effect.

By Mr. Bruce:

Q. Are there now two schools for social training?—A. No, there are seven; there were 3 of them before the war, but there have been 4 established since. There is one at Halifax, there is one at Laval University, there is one in the University of Montreal, there is one which is in loose affiliation with McGill University,—what is called the Montreal school of social work—then there is the Toronto school of social work—and there is one at the University of Manitoba and one at the University of British Columbia.

Q. When you referred to the Toronto school of social work do you mean the social department in connection with the University of Toronto?—A. It is called the Toronto school of social work.

Q. That is what I thought.—A. It is part and parcel of the University of Toronto and financed by the University of Toronto.

Q. Is it the same with the other universities?—A. It is in most cases although specifically it is not so in the case of the Montreal school of social work, which as I say has only a loose association with McGill, and which is on McGill campus; nor is it true in connection with the Maritime school.

By Mr. Mayhew:

Q. What about the other schools of social services; for instance, I am thinking of the one in Hamilton.—A. Oh, no, so far as I know there is none in Hamilton.

Q. I understood there was.—A. No. The Toronto school is financed, and is part and parcel of the University of Toronto. The British Columbia school is financed essentially by the University of British Columbia, but the provincial government in the last two years has a specially ear-marked grant, quite apart from the university grant, set aside for this social service instructional work.

By Hon. Mr. Mackenzie:

Q. Did you deal with funeral benefits and maternity benefits; how do you evaluate them say in order of precedence in the whole scheme?—A. Well, sir, I can think of a good many more important things first, that is why I did not mention them.

Mr. BRUCE: Would you excuse me if I followed that question up with one point further?

Hon. Mr. MACKENZIE: Oh, I am sorry; surely.

By Mr. Bruce:

Q. Could Mr. Davidson give us some idea of the educational requirements related to social workers?—A. Well, there are two type of program, Dr. Bruce, the basic requirement for admission to a school is a Bachelor's degree, graduation from a university; and after graduation you will find what we call two year schools and one year schools. The University of Toronto program, for example, calls for a two year post-graduate training program for graduates in Arts; but in one minor respect they make a variation; with honour graduates in the field of social science they offer a special course to permit them to get through in one year. That is also true of the Montreal school of social work. It is two years there. They have what they call a wartime accelerated program under which they are graduating people in sixteen months. The University of British Columbia and the University of Manitoba provide a one year's post-graduate course which goes from September to September and includes during the summer months a period of actual fieldwork, actual apprenticeship training out in the welfare agency where the workers are going to be employed eventually. That is one full calendar year and at the end of that time they grant them a diploma. At the University of Montreal and at Laval University as well as the Maritime School of Social Work in Halifax the basic course is a two-year one.

By Mr. Gershaw:

Q. Dr. Davidson, in speaking of child welfare needs, spoke of preventive measures that might be taken; I wonder what he has particularly in mind in so far as preventive measures are concerned?—A. I had in mind this, Mr. Gershaw; that our child protection legislation across Canada generally provides for the creation of a provincial office of child welfare and for the establishment of local children's aid societies. In some of the provinces these local children's aid societies do not exist. Then it goes on to provide that certain authorized agents may apprehend a child and bring it before a judge if found to come within any one of a whole long catalogue of categories which include wandering around with idle and dissolute persons, living under various types of anti-social conditions, begging on the streets and so on. It is a sorry catalogue of types of legal neglect, and our children's aid societies on the whole I would say have been very effective in that purely protective work, in apprehending a child and taking him before the court, having the child made a ward of society when the home situation has got to the point where it is hopeless to remedy; but what many of the societies have not done up to the present time because of inadequate funds for one thing, and because of lack of personnel in terms of numbers,—they have not been able to get ahead sufficiently in all that it is possible to do in the way of preventive treatment. Our larger and better financed children's aid societies are now developing what they call the family work department of the children's aid society through which they work with families where neglect is threatening and where there are certain early signs of parental neglect. Many of these cases come to the society's attention because of a special report by the truant officer or school teacher or by a school psychologist or by some community source. The society can go into the family situation at a time when the family situation is not hopeless, and by understanding treatment can make it unnecessary for that case to be taken before the courts and the home broken up. That is what I am thinking of in the preventive field; and that is also the point at which most of our family welfare work starts.

Mr. JOHNSTON: I wonder if Mr. Davidson will expand a little his reference to cash allowances. I understood him to say that he preferred cash allowances in relation to—

The WITNESS: Are you referring to cash benefits?

Hon. Mr. MACKENZIE: He is referring to the sickness benefit.

By Hon. Mr. Mackenzie:

Q. You had referred, Mr. Davidson, to two or three other forms of social insurance or social security in addition to the program that is now being considered; would you care to give to the committee the benefit of your opinion as to the relative priority which you think these things should be given; would you mind doing that?—A. I would want to think about it first. I would be very glad to give you a written statement on it at a later stage, but I would prefer not to give you a snap judgment.

Q. I was thinking of one, two, three, four—the order of priority.—A. Yes, I appreciate that; but I would want some time in which to think it over and I would be pleased to let you have that in writing.

Q. It would be very fine for us to have your opinion as to the order of priority.—A. I understand what you mean. There are some people who rate funeral benefits fairly high. I can think of a lot of things that are more important to me than funeral benefits.

Q. Might we have the benefit of your views on that?—A. In a written statement; yes, I will be glad to.

Mrs. CASSELMAN: Did I understand you to say that a number of provinces had organized departments for child welfare?

The WITNESS: I said that three of the provinces have in the last six months organized—it is now four provinces—departments of public welfare.

By Mrs. Casselman:

Q. Would you mind telling us who the three provinces are?—A. Alberta, one; Nova Scotia, second—in fact, there are four—Saskatchewan, only to the extent that it developed its department of labour, reconstruction and social welfare; and Quebec you may include of course because Quebec formerly had a department of health and welfare and that has now been split and they have two separate portfolios, one for health and one for welfare. There is recognition on the part of four of the provinces, three of whom had given no recognition at all to the existence of welfare services by a cabinet portfolio. I might supplement that by saying that in addition Ontario has had for a good many years two separate departments, one for health and one for welfare; and Manitoba has had for even a longer period of years a joint department of health and welfare.

By Mr. Bruce:

Q. May I just interject here; did you state that at the present time these departments in the province of Ontario are united under health and welfare?—A. Technically, no, sir.

Q. They are under one minister.—A. They are under one minister, but they are two separate entities and two separate portfolios. There is an interesting variation in that across the country which I do not think it is worthwhile wasting your time on; but under the legislation governing the creation of cabinet portfolios in the province of Ontario, there is a provision for two separate ministries, and it is purely a coincidence at the moment that Dr. Vivian happens to hold both of them. At various times both portfolios have been held under

the same minister and at other times they have been held by two separate ministers. The same would apply to other provinces. In Manitoba there is only the one minister who holds the single portfolio of health and welfare services, and there is a double portfolio of health and welfare in Nova Scotia—they just passed this Spring an amendment to the Public Service Act which provides two separate portfolios, one for welfare and one for health; and it also provides as part of the act that these two portfolios must be held by the same man.

Q. By the same man?—A. The same man.

Mr. JOHNSTON: What about Alberta?

The WITNESS: Alberta, as I recall it, has just this past session provided for a ministry of public welfare; so far as I know there is no requirement that these two portfolios be held by the same minister, although in practice at the moment they are both held by Dr. Cross.

Mr. BRUCE: There are two separate deputies?

The WITNESS: Two separate deputies, yes.

By Mr. Côté:

Q. Is there anything being done in Canada, or in any of the provinces, for the reinstatement of prisoners into civilian life by a special training or a special employment service?—A. There are what I would call very sporadic efforts, Mr. Côté; but for the most part under the auspices of the private welfare organizations which work with the local magistrate or with the local provincial jail authorities and have referred to them a person on discharge and assist them in re-establishing themselves in civilian life. I am speaking again of the city I know the best, Vancouver, where they have an organization called the John Howard Society supported by the local Community Chest and employing a full-time staff of very well qualified people—

Hon. Mr. MACKENZIE: They are doing a wonderful work, too.

The WITNESS: —who attend the police courts and who go to the prisons and contact these prisoners and help to relocate them in civilian life. In terms of provincial services I would not say definitely that there is no provincial service anywhere of that kind, but if there is I am not aware of it. I think there is need for a provincial service of that kind.

By Hon. Mr. Mackenzie:

Q. Would you advise such work being set up as part of our social service program?—A. Most definitely. I am very glad that you brought that up because I feel very strongly that our system of jails and reformatories and our penitentiary system is part of our social service program, but we have never regarded it as such in Canada. There is a very definite place for it in our concept of public service, and it has a very definite place in terms of our social program, the re-establishment of these offenders in such a way that they will become decent citizens after they leave the jails. As such, it should be a part of our social welfare work in my opinion.

The CHAIRMAN: Mr. Johnston asked a question about cash benefits which he would like cleared up.

The WITNESS: Your question was with regard to my reference to health insurance?

Mr. JOHNSTON: As to cash benefits.

The WITNESS: As I understand the present proposed health insurance legislation there is no provision for cash benefits during sickness to replace the income of a worker which he is going to lose while he is sick. You are merely going to pay his medical bill for him.

Hon. Mr. MACKENZIE: Would not unemployment insurance take care of that to a certain extent?

The WITNESS: It does not at all at the present time; it says that the man must be unemployed and available for employment.

Hon. Mr. MACKENZIE: But is it not true that the sickness benefits are generally administered under the system as it stands?

The WITNESS: It may be that unemployment insurance could be amended to meet it.

By Mr. Wright:

Q. Would you care to express an opinion as to the advisability of provincial departments being separated; would it be better if they were integrated into one or if they were separated?—A. That sir is the “hen and the egg” question. In the provincial field I would say that if you could make a final decision as to which services come under health and which under welfare, there is a case for clear separation; and incidentally I brought with me to-day a report that I have just completed for the province of Nova Scotia, for the government of Nova Scotia, and in that report I refer to this very question and I say—I think this applies to most of the provinces—that if you can separate, I would say by all means go to it and have two separate departments, one for health and one for welfare, both of them under a competent minister and administration. But, gentlemen, I would not like to have the job of deciding which services were health and which were welfare. It is very difficult to make a clear cut distinction. I am quite sure that even Dr. Heagerty here and I, or the doctors and I, or your technical medical men and I would disagree on some points as to what are health services and what are welfare services. Take mental hygiene, most medical men say that that is clearly a health service. I am not so sure of it. In that connection you will be interested in knowing that the Rockefeller Foundation which sent medical men in to make a survey of health services in the province of Nova Scotia suggested that mental hygiene services be allocated to the welfare department, whereas I as a social worker made the suggestion that mental hygiene services should be allocated to the health department. You get yourself into a real dilemma there. My solution is to avoid this dilemma by an integrated department with two deputies to ensure that you can get specialized qualified professional attention to the two types of problem. Thus you reduce your problem of allocating your services to a dispute between your deputies instead of between two ministers and at the same time maintain your departmental integration through the minister himself. This avoids the almost inevitable tendency to build up one department at the expense of the other. I think we all agree that vested interests between departments and ministers do build up. If your minister decides, for instance, that administration of a particular service should be switched from the health to the welfare side of his own department to meet a temporary situation he could make a decision for himself, whereas if you were to have two separate iron-clad departments there might be a bit of difficulty in getting one minister in a certain department to turn it over to another minister. It really becomes essentially a matter of vested interest.

Q. It is not so much a matter of vested interest as it is of passing the buck.—A. I am not so sure. The chief difficulty I have run into on that, Mr. Wright, is the unwillingness of one cabinet minister to give up an important chunk of his department to another cabinet minister, even if he is of the same political stripe.

Hon. Mr. MACKENZIE: There is a lot of truth in that. In view of your statement, would you care to comment on the proposal to provide two services in the federal department?

The WITNESS: I think that is clearly the need to-day; again, I am expressing my personal opinion, but I think it is clearly advisable to include both health and welfare in the official title of the department.

Mr. BRUCE: What you have in mind is one minister and two deputies.

The WITNESS: Yes.

By the Chairman:

Q. And right at the present time what is the relationship of your organization to the provinces; you have a branch in each of the provinces?—A. No, we are a head office organization. We think of ourselves as missionaries and we go around advising anybody who will take advice from us—

Q. Do they take your advice kindly?—A. There is a high degree of variability there, sir.

Mr. BRUCE: Is it free advice?

The WITNESS: It is very largely free advice, Dr. Bruce, we attach no price ticket to our advice, except in a case like Nova Scotia where we were asked to make a survey and we made a survey for them, and that was done on a fee-for-service basis; we often do work of that kind on a straight cost basis. We attach no price ticket to our work, however. We are supported through several grants. We get a grant from the Department of Pensions and National Health of \$8,100. Some of the provinces give us grants—Quebec is an outstanding example, they have extended us financial support to the extent of a thousand-dollar grant. Other provinces have made smaller grants. That is supplemented by local community chests and individual citizens who provide financial assistance to us; and in a variety of ways we receive assistance of that kind. I should add, since I am speaking for the record, the fact that the Canadian Life Assurance Officers Association have been very generous in the past in financing for us the deficit of our maternal and child hygiene work.

Mr. MAYBANK: Would it be useful for us to recommend a grant in this committee?

The WITNESS: I can put Mr. Mackenzie on the spot in that connection, but I don't want to.

Hon. Mr. MACKENZIE: Go ahead, I am used to it.

The WITNESS: Mr. Maybank, no grant is ever large enough.

Mrs. CASSELMAN: Then, Mr. Chairman, the different councils of social agencies I understand do not receive financial support from headquarters, they are financed by local community chests.

The WITNESS: They receive no financial support from us, and we receive no financial support from them; except for such incidental membership fee as they may choose to take out in our organization; but we work in close association on a purely voluntary basis with all the local welfare associations.

The CHAIRMAN: Are your relations with the provincial authorities agreeable?

The WITNESS: On the whole, I would say yes.

The CHAIRMAN: I notice that is qualified. Then, Dr. Davidson, I notice that you spoke about the various agencies investigating certain persons each having their own staff. Your suggestion would be that there should be one main agency?

The WITNESS: That was hardly an open suggestion, Mr. Chairman; it was a statement as to what I think is the trend in the provinces. I stated, however, that it is a plan with which I am heartily in agreement.

The CHAIRMAN: There is trend towards centralization?

The WITNESS: A trend to generalize, not to centralize; to have your welfare workers outside at strategic centres; decentralized in fact rather than the other. You have one well qualified worker to handle all types of cases, and there is where your training program comes in. You would have someone at suitable points,—Medicine Hat or some other points in a certain province,—to deal with the population of that area, so far as old age pensions, blind pensions, mothers' allowances, or the whole wide variety of social services are concerned, instead of having five inspectors all through the areas chasing each other around the larger districts.

The CHAIRMAN: You found considerable duplication?

The WITNESS: That was our experience in British Columbia when I was with the department there. We did inaugurate a generalized welfare field service, and it is that same kind of service I am indicating for the province of Nova Scotia. That is how strongly I believe in it.

Mr. WRIGHT: You think that one needs to have trained personnel, and you have now seven schools in Canada that are prepared to give training; have you any recommendation with regard to obtaining this additional trained personnel; how would you go about getting them?

The WITNESS: We have a brief that has already been submitted to the proper authorities in that connection.

Mr. WRIGHT: Will it be placed before this committee?

The WITNESS: As far as I am concerned we will be glad to present it before anybody who will read it and do something about it.

Mrs. CASSELMAN: You spoke about a pamphlet which you had sent to the members of parliament last year. Suppose that some of the members have not filed that pamphlet properly or have lost it, are there more copies available?

The WITNESS: We have a limited number.

Mr. BRUCE: Did you send your brief on personnel to anybody?

The WITNESS: We submitted this to two separate authorities in the public service. We see the problem as one of short term training and long term training for post war needs. We submitted it both to National Selective Service and the Department of Pensions and National Health.

Mr. WRIGHT: Could you give us in brief the recommendations?

The WITNESS: Our recommendation in brief is that arrangements generally similar to those with regard to the nursing profession be made in the field of social work, and that an amount of \$110,000 or \$120,000 be provided first of all to provide scholarships for an increased number of students. We are asking to strengthen the program in our schools by strengthening the staff; they are all operating on a shoestring now. And to provide a very small fund for head office or administrative supervision. At the present time we feel that our seven schools could probably double their numbers if they could get recruits and if they could get the finances for the staff. They could probably double the number of students without enlarging their physical facilities.

The CHAIRMAN: Do you suggest a grant from the federal government for these schools?

The WITNESS: That is our suggestion.

The CHAIRMAN: Through the provinces?

The WITNESS: Through the provinces or under arrangements similar to that in the nurses' group.

The CHAIRMAN: There was a question asked by the minister. I am sure the committee would like to have a statement with regard to the measures you think are urgently needed at the present time, and how these could be evolved.

The WITNESS: May I say that I never like to duck a question, but may I say again that I am in a bit of an embarrassing position here due to the fact that we have our committee of our board studying the problem, and I would not like to take advantage of that committee by expressing my own personal views in what might be thought of as an official statement before our committee itself submits its brief.

The CHAIRMAN: Would you agree to make a statement off the record for the committee?

The WITNESS: I would be glad to do that, or I would be glad also, as I already promised Mr. Mackenzie, to make a written statement. I can give you my personal view, and the official opinion will be given later.

Mr. JOHNSTON: I should like to thank Dr. Heagerty for having been instrumental in bringing Dr. Davidson here to-day, and I should like to thank Dr. Davidson for making a splendid presentation before this committee. I think it is one of the best presentations we have been given. I am sure a great deal of benefit will be derived from this presentation.

Mr. BRUCE: I should like to second that motion.

The CHAIRMAN: I was going to ask Dr. Heagerty if he had any questions to ask Dr. Davidson, as one expert to another.

Dr. HEAGERTY: The only point I was interested in was the linking up of health services with welfare services. It is my feeling that the two should be one because they are so closely related. I have not any objection to two ministers, but at the same time it might be better if there were one minister and two deputy ministers. I defer to your judgment in that because of your experience in the field of welfare, but there is no doubt that one is very closely related to the other, and they should not be separated.

The WITNESS: I have only two reasons for feeling that if the separation could be achieved it might be better: in the first place, I believe that two cabinet ministers in a cabinet fighting for social and health improvements should be able to achieve more than one, no matter how good he is; secondly—and I hope that the health people will pardon me for expressing this opinion—I labour under the feeling as most social workers do that the welfare services have too long been stepchildren to some other department. I see it as inevitable and understandable that if we have a single department of health and welfare with a single deputy minister in a single department, the deputy minister will be a medical man, a public health man, rather than a welfare man; and that is why I turn to the solution of a single department of health and welfare with two deputy ministers to achieve co-ordination at the ministerial level. Those are my two reasons for expressing the point of view that I have mentioned. I think the margin is close.

Mrs. CASSELMAN: Would Dr. Davidson be the person who would present this other report before the committee?

The WITNESS: I could not answer that. It might be myself or the chairman of the committee.

The CHAIRMAN: Can you tell us when that report will be ready?

The WITNESS: No. We have been waiting, as a matter of fact watching this committee, to find out when you were going to leave the discussion of the purely health part of the program, and we were assuming that you would give fairly extensive consideration to the larger social security proposals contained in the Marsh report. I do not know whether you are going to do that or not.

The CHAIRMAN: Consideration will not be extensive, but I hope it will be thorough.

Well, Dr. Davidson, you have heard the expression of appreciation by the committee. I would like to add my personal word of appreciation also; thank you very much.

Some Hon. MEMBER: Hear, hear.

The Committee adjourned at 12.45 o'clock a.m. to meet again at the call of the chair.

APPENDIX "A"

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Mr. W. F. Reynolds, Brockville; Col. R. F. Inch, Hamilton; Hon. Justice Robert Taschereau, Ottawa; Mr. John B. Laidlaw, Toronto; Mr. Claude E. Lewis, Toronto; Mr. A. J. Milner, Toronto; Mr. J. G. McDermid, London; Mr. Lawrence Freiman, Ottawa; Miss Elsie Lawson, M.B.E., Ottawa.

Quebec

Mr. Samuel Bronfman, Montreal; Mr. Jack Pembroke, Montreal; Hon. Louis St. Laurent, K.C., Quebec; Senator the Hon. C. B. Howard, Sherbrooke; Miss Willa Black, Montreal; Mr. Paul Goulet, Montreal; Mr. Andre Taschereau, Quebec.

Maritime Provinces

Mrs. Hugh MacKay, Rothesay, N.B.; Mr. J. D. McKenna, Saint John; Mr. J. W. Godfrey, Halifax; Mr. Harry C. Murphy, Halifax; Mr. Reginald V. Harris, K.C., Halifax; Mr. David Reevey, Saint John, N.B.

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Canada - Social Security
- 1944

SESSION 1944

HOUSE OF COMMONS

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(SPECIAL COMMITTEE)

ON

(SOCIAL SECURITY)

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 11

TUESDAY, JULY 4, 1944

WITNESSES:

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



MINUTES OF PROCEEDINGS

TUESDAY, July 4, 1944.

The Special Committee on Social Security met this day at 11 o'clock a.m., Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Bruce, Casselman (Mrs.), Cleaver, Cote, Gershaw, Hatfield, Howden, Hurtubise, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McGarry, McIvor, Maybank, Nicholson, Picard, Shaw, Wright.—19.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. J. T. Marshall, Chief, Vital Statistics, Dominion Bureau of Statistics;

Mr. H. C. Hogarth, Assistant Chief Inspector of Income Tax;

Mr. J. C. Brady, Chief, Institutional Statistics, Dominion Bureau of Statistics;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. E. Stangroom, Chief Insurance Officer, Unemployment Insurance Commission.

Two statements and a pamphlet submitted by Dr. George F. Davidson, Executive Director, Canadian Welfare Council, in reply to questions asked by Hon. Cyrus Macmillan and Hon. Ian Mackenzie at the meeting on June 22 last, were, on motion of Hon. Mr. Bruce, ordered printed in the evidence. (See Appendices "A", "B" and "C").

Clause 3 and Schedule 1 of the draft Health Insurance Bill were considered. It was agreed that specified amounts should be omitted from Schedule 1.

Dr. Heagerty was called. He suggested that the alternative plan put forward by the Provincial Ministers and Deputy Ministers of Health at their conference in Ottawa on May 10, 11 and 12, be submitted to the Dominion-Provincial Conference, together with Clause 3 and Schedule 1 of the Health Insurance Bill. This was agreed to.

It was agreed that further consideration of Clause 3 and Schedule 1 of the Health Insurance Bill should be deferred pending the Dominion-Provincial Conference.

Mr. Maybank stated that it was his understanding that Clause 4 of the Health Insurance Bill would be left open for amendment, and that he had two amendments to same that he wished to move. The Chairman pointed out that Clause 4 had been adopted but granted Mr. Maybank leave to make his motions.

Mr. Maybank moved,—“That no person shall, under any health measure that may be set up as a result, or partly as a result of the passing of this Act, be required or compelled to accept any of the benefits of any such measure, and no person shall be required under such a measure to submit to any physical, medical or surgical ministrations or treatment, if such be contrary to his religious convictions or if for other reason he objects to submitting thereto.”

Mr. Cleaver suggested the following addition thereto which was accepted by Mr. Maybank as part of his motion:—

But this exemption should not be construed as a relaxation of mandatory regulations providing for the control of communicable diseases by isolation or otherwise.

Mr. Gunn was called, and at the request of the Committee presented a motion which he prepared some time ago at the request of Mr. Slaght with reference to Clause 4 of the Health Insurance Bill. The said motion reads as follows:—

It is proposed to amend Section 4 by adding thereto the following subsection as subsection (2) thereof and to renumber as subsection (3) the present provision shown as subsection (2).

(2) It is hereby declared that, subject to the provisions of the immediately preceding subsection, nothing in this Act contained shall be construed as limiting the exercise by a province of any right of such province to define, extend or restrict the rights or obligations of any persons or groups or classes of persons in relation to any benefits or services available under any health insurance measure, or to employ and pay for the services of any persons (or organization of persons) where the services of such persons are considered by the province to be of value in the carrying out of such measure.

Mr. Maybank stated that Mr. Gunn's proposed motion embodied the two motions which he wished to make and with the permission of the Committee he would withdraw his motion and substitute Mr. Gunn's therefor.

Mr. Watson was called and examined.

After debate the Chairman suggested that Mr. Gunn's motion be submitted to a subcommittee of this Committee, to be named by the Chairman forthwith, for consideration and reference to the Justice Department; and that the subcommittee should report back to this Committee at the next meeting. Mr. Nicholson presented this as a motion and it was adopted on division.

In accordance with Mr. Nicholson's motion the Chairman appointed the following members to compose the subcommittee:—Messrs. Macmillan, Maybank, Bruce, McCann, Nicholson and Shaw. He also appointed Dr. Heagerty and Mr. Gunn to attend in an advisory capacity.

The Witnesses retired and the Committee adjourned at 12:45 p.m. to meet again at the call of the chair.

J. P. DOYLE,

Clerk of the Committee.

APPENDIX "A"

STATEMENT No. 1

IN RESPONSE TO MR. MACMILLAN'S QUESTION AS TO THE ESSENTIAL ITEMS IN A WELL-BALANCED, OVER-ALL SOCIAL SECURITY OR PUBLIC WELFARE PROGRAM

(1) *A Full Employment Policy.*—That is to say, maintenance of the highest possible degree of employment through stimulation and encouragement of private employment so far as possible, supplemented to whatever extent may be necessary by a public employment program. Only by such a policy will the earning power of the entire population be maintained and the national income kept at a level which will make it possible to finance a full and comprehensive social security program through a tolerable measure of taxation.

(2) *The Development of Adequate Minimum Wage Legislation Geared to a Decent Standard of Living.*—Full employment of itself cannot guarantee economic security to the workers of the country unless minimum wage levels are established at the same time which will provide an adequate standard of living for the workers so employed.

(3) *Family Allowances.*—Even if minimum wage legislation of acceptable standards, under a full employment policy, is achieved, Family Allowances will be necessary to iron out the differentials between the size of a man's earnings and the size of his family responsibilities. Wage levels can hardly be made so flexible as to fit the needs of every family unit large or small.

(4) *The Social Insurances.*—Even under a full employment program, based on adequate wage levels, there will be gaps and breaks in the work span of the average individual, brought about through temporary economic dislocations, social hazards such as illness, old age, or disability, or even death, and a network of integrated social insurance measures is necessary to assure the average Canadian of economic security during these periods. So far as possible, protection should be provided through the insurance principle—that is to say on the contributory basis.

The various types of insurance should be as follows:—

Insurance against unemployment, against industrial accidents (Workmen's Compensation), against sickness (both for payment of the expenses of illness and for replacement of income lost during the period of illness), insurance against old age or retirement, against long-term disabilities, and finally insurance for the family unit against the death of the breadwinner.

(5) *Social Assistance Measures.*—Even with a comprehensive system of social insurances, it will still be necessary to make provision for those who have never qualified for insurance protection (because they have never worked and contributed the necessary premiums), and for those whose need for assistance lasts longer than the benefits which they can draw under the insurance programs. These social assistance programs, all of which are financed from tax funds, and are not based on the contributory principle, include the following:—

Old Age Pensions (non-contributory), Pensions for the Blind, Mothers' Allowances, relief on the basis of need for unemployables, adequate work relief programs for the unemployed insured, medical care for the needy (unless they are to be considered in a Health Insurance program), foster home care for dependent children, special assistance to the transient, and last but by no means least, an adequate program of farm relief.

(6) *Specialized Social (i.e., health and welfare) Services*—There is a difference between economic security and social security. The services which are included in this group are designed to deal with those problems of a social nature which cannot be eliminated altogether, even though they may be in part, by solving the problems of economic security. Included in this field are a wide variety of public health programs, as well as our programs of child care and protection, juvenile delinquency control, assistance to the unmarried mother and her child, and finally our programs designed to deal with the problem of adult crime which should be dealt with on the basis of social treatment and social service.

APPENDIX "B"

STATEMENT No. 2

IN RESPONSE TO MR. MACKENZIE'S QUESTION AS TO THE ORDER OF PRIORITY
WHICH SHOULD BE GIVEN TO THE INTRODUCTION OF VARIOUS
SOCIAL WELFARE AND SECURITY MEASURES

Reference is made to page 115 of the Marsh Report on Social Security, where Dr. Marsh suggests two different orders of priority, depending on whether the question is being viewed from the standpoint of over-all considerations, or from the immediate post-war angles relating to the immediate needs of the transition period.

The order of priority given below in this statement does not agree precisely with either of Dr. Marsh's suggested lists. It rates the extension of Unemployment Insurance, for example, lower than Health Insurance, Children's Allowances, or the Disability, Old Age, and Survivors' group of insurance, on the grounds that the inauguration of these important new programs is more important than the introduction of detailed changes in existing programs. For similar reasons, funeral benefits, maternity benefits, and to a lesser extent, sickness cash benefits, which can best be regarded as an improvement and extension of our present Unemployment Insurance legislation, are set relatively far down on the scale of priority.

Attention is drawn to one further point of importance. The two items which head the list of priorities are not shown in Dr. Marsh's list at all, and ordinarily are not considered as being part and parcel of a public welfare or social security program in the narrower sense of those terms. In the opinion of the writer of this memorandum, however, they constitute the basis upon which any well-conceived social security structure must be built because the fact must be faced that our social security measures such as the social insurances and other social service programs cannot be effective in bringing security to the Canadian population if we fail to maintain a high degree of employment, or if we fail to provide a decent level of living for those who are employed. A low level of employment could easily prove disastrous to our Unemployment Insurance program, and would likewise nullify the effectiveness of other social insurance measures. A low wage level providing an inadequate standard of living for the working population of our country would create, during the very period when people are employed, the same conditions which our social insurance programs are designed to prevent during periods of unemployment for any reason, and our social insurance and other welfare measures would not be effective in dealing with these conditions, being designed essentially to provide protection during those periods only when normal sources of income from wages or other channels have been discontinued. Hence the importance of basing our entire social security program on basic policies which are designed to provide the highest possible level of employment for all the working force of the country, and to establish for this working force wage levels which will make it possible for the population of Canada to maintain, during their periods of employment, a reasonably adequate standard of living.

With these prefatory remarks, the order of priority suggested is given below:—

1. Maintenance of the fullest possible measure of employment.
2. Establishment of adequate minimum wage levels.

3. **Children's Allowances.** These are placed high on the order of priority, not only for the reason that there are no differentials in the wage structure relating it to the size of a man's family responsibility, but particularly because they simplify the whole structure of benefits to be paid under our various cash insurance programs. If Children's Allowances are being paid, our social insurance scale of benefit can be greatly simplified and reduced, as in the case of Unemployment Insurance to-day, to one scale of benefits for the single man and another for the married couple. No further variations in scale of benefit are necessary to meet the needs of the children in the family unit because these needs will be taken care of, at least in part, by Children's Allowances. At the present time, however, Unemployment Insurance scales of benefit are subject to the criticism that they make no provision whatsoever for the number of children dependent on the person drawing insurance. The unemployed insured wage earner with five children draws the same benefit as the unemployed insured wage earner with a wife and no children; nor is there any Children's Allowance system in operation, side by side with Unemployment Insurance, to make the necessary adjustment.

4. **Health Insurance.**—As stated by Dr. Marsh, this should rank particularly high in the list because it is applicable to the whole population (that is to say, to the wage earning population and to the non-wage earning groups as well) and is most likely to produce rapid beneficial effects. It is assumed that this will be a provincially administered measure with Federal grants-in-aid, in which case care should be taken to avoid, by any means that may be possible, the collection of contributions by the Provinces in a manner that may later interfere with the Federal Government's desire to collect a single-over-all, integrated premium for all the Federal social insurance measures.

5. **Old Age and Retirement Insurance** (including disability insurance which is really premature retirement)—This too is important in that it applies both to the wage earning and to the non-wage earning section of the population. It is of particular significance to note in this connection the arguments of Sir William Beveridge, which apply with equal effect to Canada—i.e., that ours is an aging population, and further that the future burdens of assistance to the aged will probably constitute the most serious financial load of all these public welfare programs. It is therefore of the utmost importance that we shift the burden of this problem from general tax funds to the basis of contributory insurance at the earliest possible moment.

6. **Survivors Insurance** (sometimes known as widows and orphans contributory pensions).

7. **Strengthening and extension of Unemployment Insurance**, including an amendment which will provide sickness cash benefits on the scale of the present unemployment benefits during those periods when the worker is unavailable for employment because of illness, as well as during those periods when at present he is unemployed but available for employment. It will be noted that this is much lower on the scale of priority than Dr. Marsh would put it. I think he probably rated the extension of Unemployment Insurance as high as he did with the thought in mind that we already have the basic legislation and we could proceed immediately to make improvements and extensions to it. I am not denying or questioning the importance or value of these improvements, but I question whether they have the over-all importance that some of the above-mentioned programs have.

Finally, at the very bottom of the list, I would put Maternity Benefits, and lower still, Funeral Benefits. I doubt very much whether the provision of a lump sum Funeral Benefit would accomplish any useful purpose. It would not have the desired effect of controlling funeral expenses, and would simply mean that the relatives of the deceased would probably take the lump sum Funeral Benefit and have to add to it an additional sum of money to provide a funeral on the basis of existing undertakers' fees. The solution of this problem lies, to my way of thinking, in the direction of price control designed to make funeral costs reasonable, rather than in the payment of a lump sum Federal Benefit.

In conclusion it should be pointed out that no attempt has been made to relate the suggested order of priority for programs in which the Federal Government may be required to take the initiative with the order of priority in regard to those public assistance and other social services which are generally accepted as falling exclusively within provincial jurisdiction. In regard to these programs, such as general relief both for the unemployed, uninsured, and for the unemployables, Mothers Allowances, non-contributory Old Age Pensions, etc., it can be stated that most of the Provinces have already programs in operation which cover, with varying degrees of adequacy, the social needs arising in these areas. There is almost uniform need for a strengthening of these provincial services through the provision of more adequately qualified personnel and through the establishment of more adequate levels of assistance.

It is difficult, if not impossible, to relate the relative importance of this to the order of priority outlined above since we two fields operate side by side. It is difficult to see, however, how even early action in respect to the social insurances can establish these programs on a firm enough basis to stand the possible shocks of post-war dislocation, and this fact in itself underscores the importance of strengthening our public assistance and other social service programs, which are essentially based on the non-contributory principle and are largely within the sphere of the Provinces, at the same time that we are building these new social security programs on the Federal level.

APPENDIX "C"

THE FUTURE DEVELOPMENT OF SOCIAL SECURITY IN CANADA

GEORGE F. DAVIDSON, M.A., PH.D.

Executive Director, Canadian Welfare Council

If we were to approach our problem in a thoroughly logical way, we might begin by attempting to set up a definition which we all might agree upon for the term "social services,"—where they begin and where they end, in the sum total of our activities as an organized society. But we shall not do so: first of all for the very good reason that it would involve us in endless difficulties—for example, do we include housing in our concept of the social services—or works programs—or employment services, or the social insurances, or the health services, or the administration of penal institutions, or education; secondly, because within reasonable limits I think we can all understand what we mean by the term without attempting to define it precisely or to reach exact agreement on every point of detail.

One comment, however, I do feel bound to make at the outset with reference to the title of this paper. We should not be deluded by the use of the word "future"; no more should we allow ourselves to be lulled into a false sense of security through the "post-war" part of post-war reconstruction. Here is emphatically one phase of our total war effort where time will *not* be on our side unless we realize that in large measure post-war reconstruction depends on plans laid, on steps taken *to-day*. Likewise to-morrow's social services depend, not on some magic rabbit, to be pulled out of a hat full of war-time promises, after the fighting is over.

To-morrow's social services are being built to-day. They are being built in their broadest outlines by the purposeful utterances of Prime Minister Churchill and President Roosevelt when they refer in the fifth article of the Atlantic Charter to the "desire to bring about the fullest collaboration between all nations in the economic field *with the object of securing for all, improved labour standards, economic advancement, and social security.*"

They are being built too in their broadest outlines by the utterances of British church leaders, as witness such landmarks as the joint statement of the past and present Archbishops of Canterbury, the Roman Catholic Archbishop of Westminster and the Moderator of the Free Church Federal Council, entitled "Foundations of Peace" (*London Times*, December 21, 1940): or again the present Archbishop of Canterbury's earlier statement "Begin Now" appearing in *Christian Newsletter* of August, 1940. These and many other similar pronouncements set the general framework within which we have to contemplate the setting of our social services in the post-war world.

This paper, by the Council's Executive Director, the third in the series of articles appearing in *Welfare* on various phases of post-war reconstruction, was first given at the Y.M.C.A. Institute of Public Affairs, at Lake Couchiching, Ontario, in August, 1942. It appears here, not as an exposition of official Council policy, but as the expression of an individual point of view in the hope that, coincident with the interest being shown in the Beveridge Report, it may help to stimulate thinking on this subject by social workers, lay and professional, throughout Canada.

As Edward Phelan of the International Labour Office wrote in his article, "The New Social Objectives," which appeared in *Canadian Welfare* for October, 1942:—

We are constantly being reminded that the main objectives of the present war are social rather than political or even economic. President Roosevelt has told us to look forward to a world where we shall enjoy freedom from fear and freedom from want. Mr. Eden reminds us that the British Government "has declared that social security must be the *first* object of our domestic policy abroad not less than at home." "My War Aims," says Ernest Bevin, "are summed up in the phrase, 'the motive of our life shall be social security'." Vice-President Wallace declares that the century which will come out of this war "*can* be and *must* be the century of the common man.

Finally, to bring the matter nearer home, we have the statement of the Honourable Ian Mackenzie, quoted in Mr. Eckler's article, "The War for Social Security," which appeared in *Saturday Night* for August 15, 1942:—

Few to-day can regard war as an adventure, and therefore it only becomes tolerable as a crusade with social and economic reform as a banner under which we fight.

I hope that I will not be misunderstood when I say that there is good reason in one respect for us to be grateful to Hitler and his awful gang in forcing us, as they have done, to search our collective consciences for the purpose of formulating national purposes, national resolves, national objectives that are positive and social in nature rather than merely negative. Is it too much to say that there is a vast gulf between the objectives that we were consciously aware of having when we entered this war, and the socially progressive objectives for which our leaders tell us we are fighting to-day?

It is not for me to analyze all the reasons which lie behind the slow emergence of these social objectives in the present struggle. Suffice it to say that the leaders of our English-speaking countries have seen the need to vitalize the spirit of their peoples by adding to the objectives of which we were conscious when we entered the war, namely, the things we were fighting *against*, a set of new objectives, a positive set of social goals that we now are fighting *for*.

The important thing from the point of view of our present discussion is that these objectives which we have chosen, to impel us on to greater efforts in the war, are *social* objectives. The relationship between our social service programs in the broadest sense and the factor of national *morale* both in civilian occupations and in our military efforts, has at last been recognized in England and in the United States. One dares to hope that it may even yet be recognized in Canada, not merely in terms of lip service, but genuinely in the hearts and souls of our leaders and of our people. If this can be brought to pass in Canada, then victory when it comes will prove to have been well worth the cost, and the people's war will have been in the truest sense a people's victory.

With these preliminary remarks to set the background for our discussion, let us turn now to some more practical consideration of the methods by which these high social purposes can be achieved for the Canadian people. First let us sketch in briefly, but as fully as the time allows, the types of service programs which are indispensable to the attainment of social security on a national scale. I shall endeavour to do this initially without too much thought of the baffling question of jurisdictions, constitutional responsibilities, or financial limitations, as between the various levels of government, federal, provincial, and municipal. Later attention will be given to consideration of jurisdictional and other problems.

FULL EMPLOYMENT

The first, and probably the most important elements in the development of an adequate program of social security for Canadians are those which centre around the concept of "*economic*" as distinct from the more *comprehensive* "social" security. For it is well to remember that there is a difference between economic and social security. The first step in the achievement of economic security is, of course, *the provision of full employment*; perhaps more realistically expressed as the avoidance of mass unemployment. It can quite properly be said that any program designed to provide full employment is a social service insofar as it is *an activity of society pointed toward a social objective*.

It can also be said that many of the elements which go into the development of a policy of full employment are in themselves social service programs in a double sense. For example, the tremendous housing program which simply must be undertaken in this country in the post-war period, if indeed not before, —a program of unprecedented extent which will be inadequate if it fails to re-house anywhere from one-quarter to one-third of our entire population; or again, a program of parks and playground development designed to produce adequate breathing spaces for our city dwellers; or still again a program of useful government-sponsored public works, planned and timed to iron out the troughs and ditches in the post-war employment curve.

Full employment policies based on long range economic planning, on considerations which take into account the opportunities for development of export markets and for the social development of our natural resources gain a double social emphasis when they resort even periodically to housing, parks and playground development and similar works programs geared to a specific social objective.

MINIMUM WAGE LEGISLATION

Full employment, however, will not of itself achieve that goal of "*freedom from want*" that President Roosevelt has hung like a Holy Grail before the hungry spirits of the democratic peoples of the world. To achieve the fuller goal of freedom from want or economic security for all the people full employment must be bolstered with additional measures of social legislation. Full employment of itself is a hollow mockery unless it provides an adequate standard of living for the workers so employed: and attainment of economic security for the workers of our country involves the development of minimum wage legislation in all our provinces that will produce uniformly from full employment a living level for the employed that will be truly "*freedom from want*."

FAMILY ALLOWANCES

But even wage levels in their turn cannot be made so flexible as to fit the needs of every family unit, large or small. If there are those who take the view that wages can be based on social considerations and considerations of the size of individual workers' family responsibilities instead of on the principle of "equal pay for equal work", I am afraid that I cannot go along with them. The adjustment of family income to family responsibilities must be made in my opinion through a system of family allowances, supplementing wages earned with an allowance, as a matter of right, not of need, for every child in the family unit. This system has been widely adopted in European countries, and also in Australia and New Zealand. It is becoming an increasingly live issue to-day in England where organized labour's opposition to it, on the grounds that it depresses wage levels, is rapidly disappearing. In Canada the issue has been a dead one since the Parliamentary Committee of 1929 turned it down, but it is destined, in my opinion, to come to the fore again as an issue well worthy of con-

sideration in our planning for social security. To-day's income tax exemption of \$108 per child is in effect *for taxpayers* but not for the lowest one-third of the population, a system of family allowances *in reverse*.

This then is the keystone of our arch, the foundation stone of the edifice of social security which we must start to build to-day for the Canada of to-morrow—full employment, including the development of socially useful programs such as housing and other projects, supported by an adequate wage structure guaranteed by law, and a system of family allowances to supplement the worker's wages by an amount necessary to fill the gap between his earning power and his family responsibilities.

But there is more to building an edifice than the mere laying of the foundation stone. Let us try then to move some other pieces into place.

SOCIAL INSURANCE

I hope that I will not be thought unduly pessimistic if I suggest that full employment in Canada in the post-war years may not be achieved, or rather that the full measure of employment brought about by war may not always be maintained. There must be a second set of defences to fall back on. These are, in my opinion, *the social insurances*—insurance against those risks which may prevent the individual wage-earner from maintaining the full degree of economic security which our program, as thus far outlined, contemplates. Insurance against unemployment, against industrial accidents, against sickness, against old age, against long-term disabilities, insurance for the family unit against the death of the bread-winner—I need only recite these various types of social insurance for you to recognize them or at least the most of them. Unemployment insurance and workmen's compensation we already have in Canada, though their scope is still limited. Health insurance, survivors' or life insurance, sickness and accident insurance, disability insurance, old age insurance—all of these too we have, *but on a commercial not on a social basis*.

If these forms of protection are desirable for those who, like ourselves, can afford them on a commercial basis, how much more are they *desirable*, or even *necessary*, for the lower, less secure and less protected income groups? These groups, however, cannot afford to purchase protection on a cost plus basis. The vast majority cannot even afford to pay the actual costs involved. Hence the developments, already tested for half a century or more in other countries, to socialize these types of protection, to socialize these insurances, by eliminating the commercial profit, and by absorbing further a portion of the actual cost of the insurances through contributions by governments and by industry, leaving the individual to bear only that portion of the actual cost which he can properly afford to pay.

SHOULD INSURANCES BE CONTRIBUTORY?

Objection may be raised at this point to the idea of maintaining these protective services on an insurance basis, and I am free to admit that there is much to be said for the idea that we should short cut, for example, the cumbersome procedure of collecting premiums from individuals, of levying contributions on industries for say health insurance, by introducing an outright system of state medicine. The bureaucracy of the premium-collecting agency is truly a fearsome thing to contemplate for all of these insurances. Why not provide unemployment benefit as a matter of right paid for, not partially by premiums, but entirely from taxation? Free medical care, free hospital care, paid for from general taxation? Old age pensions for all as a matter of right, regardless of specific individual contributions? And so on down the line. Why, the cumbersome insurance principle when straight taxation will do the job?

Well here perhaps I may be branded as a "wavering progressive" or possibly an "unwavering reactionary". I know what hateful connotations are attached to the phrase "rugged individualism", and I doubt whether anyone who has followed my argument thus far would suggest that I was exactly an outstanding exponent of that particular philosophy. Yet I do sincerely wonder whether it is altogether wise to abolish completely the contributory feature of these social insurance schemes. Is there not something of value in maintaining the contributor's sense of individual participation in the scheme? Should he not be a supporter of it directly as well as a beneficiary? Does he not retain a certain measure of control over his rights as a contributor, even if it is only an ability to work up a feeling of righteous indignation, that might be lost to him otherwise? I confess I feel on shaky ground at this particular point. But, certainly, the experience of non-contributory old age pensions has not been a reassuring one, nor the experience of mothers' allowances, nor of unemployment relief. In all of these, of course, the answer is that the means test was involved—the means test was and is the cause of their unsatisfactory performance. I know that that is so, and it is precisely for this reason that I cling to the contributory phase of the insurance program, because I think it entirely likely that these programs, if not maintained to some extent on the contributory basis, will some day under extreme financial pressures, which particular periods may throw upon them, be tempted to introduce means test considerations by some round-about method.

I will leave these issues, however, to be debated at greater length on some other occasion, and pass on to other considerations.

SOCIAL ASSISTANCE BASED ON NEED

These considerations involve the fate of two groups in particular, who have fallen through the protective mesh of *first*, full employment with adequate income, and *second*, insurance protection on a contributory basis against the major hazards outlined above. Some classes of our people cannot be absorbed into any employment market, no matter if it is full to the bursting point. They cannot maintain themselves by wages earned, and the family allowance, if payable, is not sufficient to replace but only to supplement real wages. The social insurances likewise cannot protect this group, except insofar as it might be possible for the government to pay full premiums for them, because they themselves cannot contribute from non-existent wages, and have no employer to contribute his share on their behalf.

Then, too, there is that group of persons who have fallen out of employment as a result of one of the social hazards mentioned above, and who have eventually exhausted their right to insurance benefits, without being able to return to available employment. For all of these some adequate program based on need must be devised. These are in fact our present day public assistance services which must be extended, broadened and at the same time more intelligently and humanely applied. Old age pensions (non-contributory), pensions for the blind, mothers' allowances, relief at need to unemployables, work relief for the unemployed (along lines consistent with the maintenance of skills and human dignity, similar to the Work Projects Administration in the United States), medical care for the needy, foster home care for dependent children, special assistance to the transient, and last but by no means least, an adequate program of farm relief. The elements of all these programs are to be found at the present time in our Canadian experience. They need to be broadened, developed, and applied on a scale that will make them effective cushions of social protection for all the people.

THE SPECIALIZED HEALTH AND WELFARE SERVICES

These three broad levels of protection: (1) Full employment on adequate wage levels with family allowances; (2) Social insurances fully developed; and (3) Public assistance by categories at need, will, in my humble opinion, do much to assure *economic security* to the people of Canada. But I said earlier that economic security is not synonymous with social security. Freedom from want, the abolition of poverty is not the entire answer. There are environmental hazards and social hazards to guard against even in a land flowing with milk and honey. The milk, in fact, may not be pasteurized: and to guard against these environmental hazards, both physical and social in nature, we must provide a network of special services which do not fall altogether neatly into the categories of economic security measures that I have outlined above. The public health services, for example, with their over-all health units, their preventive programs for child health, their sanitation services, their public health nursing services, their services for the control of communicable diseases, their specialized efforts in the fields of tuberculosis and venereal disease control, their tremendous responsibilities in the field of mental hygiene and care of the mentally ill and mentally defective,—all these must find a place in our scheme of social security, because the problems which these programs are designed to attack do not vanish altogether, though they do in part, by solving the problems of economic insecurity. Then, too, we must include those social services which are designed to deal with the special problems which arise out of anti-social behaviour of some of our citizens—child care and protection from neglect, juvenile delinquency, the problem of unmarried parenthood, the problem of adult crime which requires, despite what we tolerate in Canada, to be handled as a social service problem. Say what you like about a large measure of these problems involving anti-social behaviour being rooted in the inadequacies of our economic system. I will go along with this line of argument as far as most people; but I will *not* agree that the abolition of poverty in the broadest sense of the term will ever completely remove the need for programs designed to deal with these peculiar types of social inadequacy and maladjustment rather than economic insecurity.

And, now, if I may, I would like to devote a brief amount of time to the auspices under which this over-all program of social, health and economic security should be developed.

THE NEED FOR NATIONAL LEADERSHIP

The first and the obvious thing which must be said is that any national program of social security for Canada must be developed, if it is to be based on a Canadian standard of living, if it is to be a Canadian system of social security, under the aegis of the only government that can develop anything for all of Canada,—that is the federal government. We cannot have nine Canadian social security programs. If we want a social security program for British Columbians or for Manitobans or for Nova Scotians, that is one thing; but whatever it is, it is not and never will be, if you multiply it nine times or ninety-nine times, a Canadian program of social security.

This means to me that the leadership behind any concept of social security for the nation, no matter how humble, no matter how ambitious it may be, must be assumed by Ottawa. The government of Canada cannot operate in a jurisdictional or constitutional vacuum if it is to be a government of the Canadian people. It must accept responsibilities for leadership in the social welfare field; for it is *national morale* that makes or breaks a nation; and national morale, as we are beginning to find out in this war, depends, far more than this country has hitherto realized, on the sense of security provided on the home

front by a network of social services. Did anyone ever hear of *provincial morale*? Only national leadership therefore by the Dominion Government can create that social dynamic from which will result a program of social security to buttress our well-being as a nation.

CONDITIONAL GRANTS-IN-AID

There is a difference, however, between national leadership in the planning and conception of a national social service program, and out-and-out national administration. Just because I am advocating national leadership does not mean that I could agree to administration of the entire social security program outlined above by the national government as either necessary or desirable. Here I would take issue with some of the recommendations of the Rowell-Sirois Commission. I believe with the Commission that administrative jurisdiction for many phases of the security program should be vested in the Dominion Government, but I cannot agree that the Dominion-supervised provincially-administered program based on Federal grants-in-aid should be relegated to the insignificant position assigned to it by the Commission. I do not believe the conditional grant-in-aid was adequately appraised as a medium by which we might get around the constitutional impasse in respect to the financing and administration of our social services. We have really two alternatives: clear cut separation of jurisdiction and administrative responsibility strictly on constitutional lines with one group of services being administered by the provinces and one by the Dominion; or, the conditional grant-in-aid principle by which the Dominion, administering certain services directly can also influence in terms of standards and extent of program the services administered by the provincial governments. I can see no possibility of a well-integrated national program of social services, if the Dominion, following the Rowell-Sirois recommendation, takes over certain administrative responsibilities on its own shoulders, but, while granting large sums of money to most of the provinces, maintains a strictly hands-off, disinterested attitude in respect to the extent or quality of the provincially administered programs. The best that could result from this would be a patchwork, though it might, of course, produce a pretty good patch here and there.

Nor is the answer to be found in practical terms in the Dominion taking over *administrative* responsibility for all the social services. If unemployment insurance is any example, we would have to wait till Doomsday to get the necessary number of amendments to the British North America Act to accomplish this. We need our social security program *now*, not on Doomsday. Then too there are other fundamental objections to the Dominion taking over full administration. Certain services are essentially local in their nature. But what is needed is a program of Dominion administration in part, plus Dominion interest through grants-in-aid, supervision and field service to provinces in respect to the provincial services, with over-all Dominion leadership, stimulation, planning and integration. Grants-in-aid have worked in the United States with its federal system. They have worked for an even longer period in Britain. They can be made to work with reasonable satisfaction in Canada. The reason for such failure as has been experienced in the past, and this is in part the reason why the Rowell-Sirois Commission damns the device with faint praise, is due to two things: (1) political intervention, (2) lack of adequate supervisory personnel on the Dominion level for other than audit purposes. Political non-intervention and development of adequate personnel for Dominion leadership as well as for Dominion and provincial administration are, of course, two of the indispensable prerequisites to the success of a conditional grants program. But that is true of any program, and neither is impossible in Canada if there is a serious desire evident to attain these objectives.

FEDERAL RESPONSIBILITIES

Personally, I would say that of the various items in the social security program above outlined, responsibility for the provision of full employment, minimum wage levels and family allowances should be Federal responsibilities. Responsibility too for the social insurances should be federal. In this one might make an exception of workmen's compensation, and possibly also as the Rowell-Sirois Commission does, health insurance, although, frankly, I see no reason in principle for leaving health insurance with the provinces, except that through doing so we may get health insurance more quickly if provincially administered with federal grants-in-aid.

PROVINCIAL RESPONSIBILITIES

The assistance services and the special health and welfare services designed to deal with problems of anti-social behaviour should probably be left administratively with the provinces, but with Dominion grants-in-aid and supervision. These services based on assistance at need are for the most part more subject to legitimate local variation than the other services, and can therefore be administered on the whole more adequately under local auspices than the other services, such as the insurances, where provincial jurisdiction would involve serious administrative difficulties. Here again I touch upon a highly controversial point, and I know that my opinion will be unpopular when I say that I am not convinced that an exception should be made of unemployment aid by turning it over administratively to the Federal Government as recommended by both the National Employment Commission and the Rowell-Sirois Commission. I think that with a policy of full employment, including responsibility for work projects, plus comprehensive insurance protection, the problem of unemployment aid can well be left administratively with the provinces under federal supervision with federal grants-in-aid.

Space, of course, has not permitted me to do other than state categorically my opinion on this question of allocating administrative responsibility between the federal government and the provinces. But one of the advantages of the grant-in-aid principle is that it allows greater flexibility, and therefore assignments of responsibility to the province or to the Dominion can be made tentatively as I have done above, and there is nothing irretrievable about the result.

On the other hand, if you attempt a clear cut separation of jurisdiction as the Rowell-Sirois Commission did, you come to the awful point where you have to make up your mind once and for all—Is health insurance going to be left with the provinces or is it going to be a function of the Dominion? There is an embarrassing dilemma created every time a final decision is made. The result is that the Commission report is full of inescapable inconsistencies as a result of the attempt to separate clearly the respective jurisdictions.

FEDERAL BUREAU OF PUBLIC WELFARE

Two final points and I am through. I have pointed out the need for national leadership in the social welfare field. This means to me the early establishment of a Bureau of Public Welfare on the federal level which will at least serve as the nucleus for the development of this national social security program.

TRAINING FACILITIES FOR PERSONNEL

And then my final word. One thing that frightens me more than almost anything else as we face the social service developments of the post-war world is our utter lack of preparedness in terms of personnel trained in social welfare

principles and administration. I would be the last to want to take anything away from our colleagues in the health and educational fields. But the large Foundations have been most generous to these fields in their assistance towards the development of training schools and qualified personnel. The need is great for similar interest to be shown in our schools of social service administration. Nothing would be more pathetic than to have Canada embark upon a post-war program of social security with inadequate personnel. Yet that is what will surely happen unless the leadership is found to make it possible now to develop the research and administrative personnel for the Canadian program that we visualize in the post-war world.

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SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

MINUTES OF PROCEEDINGS AND EVIDENCE

No. 12

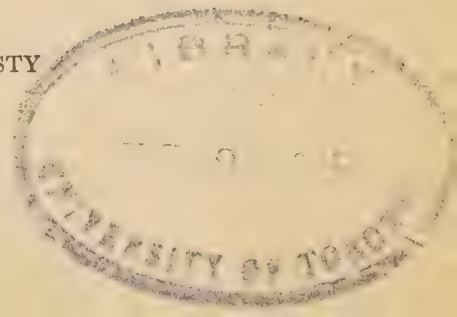
THURSDAY, JULY 13, 1944

TUESDAY, JULY 18, 1944

WITNESS:

Dr. F. Cyril James, Principal and Vice Chancellor, McGill University,
Montreal, P.Q.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



ORDER OF REFERENCE

TUESDAY, July 18, 1944.

Ordered,—That the said Committee be granted leave to sit while the House is sitting.

Attest.

ARTHUR BEAUCHESNE,
Clerk of the House.

REPORT TO THE HOUSE

OTTAWA, July 18, 1944.

The Special Committee on Social Security begs leave to present the following as its

SECOND REPORT

Your Committee recommends that it be granted leave to sit while the House is sitting.

All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

MINUTES OF PROCEEDINGS

THURSDAY, July 13, 1944.

The Special Committee on Social Security met this day at 11.00 o'clock, a.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present: Messrs. Adamson, Blanchette, Breithaupt, Bruce, Casselman (Mrs.), Cleaver, Cote, Fulford, Gershaw, Howden, Lalonde, Mackenzie (*Vancouver Centre*), MacKinnon (*Kootenay East*), Macmillan, McCann, McIvor, Maybank, Mayhew, Shaw and Wright—20.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. R. B. Bryce, Financial Investigator, Department of Finance;

Mr. S. B. Smith, Dominion Bureau of Statistics.

The Chairman reported that the Subcommittee appointed at the last meeting to consider Mr. Maybank's motion and get an opinion from the Justice Department on same, had met and secured the opinion of the Deputy Minister of Justice which is as follows:—

I have given consideration to the proposed amendment to Section 4 of the draft National Health Act by adding a new subsection (2) in the following terms:—

(2) It is hereby declared that, subject to provisions of the immediately preceding subsection, nothing in this Act contained shall be construed as limiting the exercise by a province of the right of such province to define, extend or restrict the rights or obligations of any persons or groups or classes of persons in relation to any benefits or services available under any health insurance measure, or to employ and pay for the services of any persons or organizations of persons where the services of such persons are considered by the province to be of value in the carrying out of such measure.

I would not advise the adoption of this amendment for the reason that its terms are so general that they might be construed as nullifying in large measure the conditions under which the grants to the provinces may be made. I refer particularly to the proposal to declare in effect that the province is to be free to extend or restrict the rights or obligations of all persons in respect of benefits or services available under the Act. Such a general declaration, embracing as it does the whole field of rights and obligations, even when qualified by the phrase "subject to the provisions of the immediately preceding subsection", suggests that a province is to have authority to depart in some important respect from the plan if it chooses to do so. In any case, such an amendment, to my mind, will lead to confusion in construing the legislation.

The declaration that the province may employ and pay for the services of persons whose services are considered by the province to be of

value, is open to the objection that persons might be paid out of the grant who are not qualified medical practitioners according to the law of the province.

For these reasons I advise that the proposed amendment is undesirable.

(Signed) F. P. VARCOE,
Deputy Minister.

The Chairman stated that the Subcommittee having carefully considered the motion and the opinion of the Deputy Minister of Justice, decided, on division, against recommending the adoption of Mr. Maybank's motion.

Mr. Maybank did not disagree with the opinion of the Deputy Minister of Justice but thought that it was based on a wrong premise.

Hon. Mr. Bruce read the following memorandum to show why the amendment should not be adopted:—

Section 3 (1) of the draft Health Insurance Bill confers upon the Governor in Council the powers to make an agreement with the provinces for the payment of grants for health insurance. Section 4 (1) confers upon the Governor in Council the powers to approve statutory provisions respecting health insurance laid down in the Second Schedule to the draft Health Insurance Bill. The Governor in Council, therefore, is empowered to enter into an agreement with the provinces and to indicate the statutory provisions that will be satisfactory for the purpose of such grants. The draft Provincial Model Bill contains the statutory provisions. These are the basis for an agreement between the Governor in Council and the Lieutenant-Governors in Council of the various provinces.

The motion before the Special Committee on Social Security is designed to limit the powers conferred upon the Governor in Council by Sections 3 (1) and 4 (1) of the draft Bill, as the following section of the motion indicates:—

Nothing in this Act contained shall be construed as limiting the exercise by a province of any right of such province *to define, extend or restrict the rights or obligations of any persons or groups or classes of persons in relation to any benefits or services* available under any health insurance measure.

This section of the motion substitutes for the conditions laid down in the Second Schedule to the draft Bill those to be determined by the Lieutenant-Governors in Council of the provinces. Virtually, the powers conferred upon the Governor in Council by Section 4 (1) to determine the conditions on which an agreement may be made have been transferred from the Governor in Council to the Lieutenant-Governors of the provinces. The Governor in Council is bound by this motion to accept any definition, extension or restriction of the Second Schedule to the draft Bill which may be made by the provinces.

It was never the intention of the draft Bill that the Lieutenant-Governors in Council of the provinces should lay down the conditions under which they would be willing to accept Dominion grants, but it was the intention that the Governor in Council and the Lieutenant-Governors in Council should enter into a mutual agreement for the provision of benefits subject to the conditions laid down in the draft Health Insurance Bill or substantially in such terms.

The enacting part of the proposed amendment which reads as follows:—

It is hereby declared that subject to the provisions of the immediately preceding subsection has no significance inasmuch as the conditions laid down by the motion nullify the provisions of Section 4 (1) to which it refers.

Regarding the last part of the proposed amendment, as follows:—

or to employ and pay for the services of any persons or organizations of persons where the services of such persons are considered by the province to be of value in the carrying out of such measure

it would appear that the object has been to deprive the Governor in Council of the right of refusal to accept even the most untrained and incompetent persons authorized by a province for the purpose of providing benefits under the Bill. It is conceivable that extreme pressure might be brought to bear upon a province to permit unqualified persons to provide benefits and that a province might not be able to resist such pressure. In this event, the Governor in Council should have discretionary powers.

Briefly, this proposed amendment authorizes the Lieutenant-Governors in Council of the provinces to set aside those sections of the draft Bill which have to do with the persons covered by the Act, with registration, contributions, benefits, method of payment, creation of a Health Insurance Fund, all of which are pertinent to the agreement to be entered into between the Governor in Council and the Lieutenant-Governors in Council of the provinces. Inasmuch, therefore, as the proposed amendment would enable the provinces to circumvent the objects of the draft Bill, as indicated in the Second Schedule, it should not be adopted.

In other words, the provisions of subsection one of Section 4 and the proposed subsection two are contradictory, unworkable and cannot be read together, as, in the first instance, it is declared that "the statutory provisions as respects health insurance" shall be "as set forth in" the draft Bill, and, in the second case, that the Governor in Council will have to accept the definitions, extensions and restrictions in relation to benefits and services which the provinces have a right to impose in ordinary circumstances when dealing with their own laws and their own funds.

The distinction is here brought to mind of the difference between unconditional and conditional subsidies and of the superiority of the latter. Unconditional subsidies have no redeeming features. On the other hand, if money is to be raised by one government and handed to other governments to spend, the government which raises the money and makes the grant should assert its control by specifying the purposes for which it will give assistance and by reaching after the money to see that it is properly spent. Otherwise, the grant for certain services may defeat itself, the money may be ill-spent and the services slighted.

This matter is dealt with by J. A. Maxwell, in his book, "Federal Subsidies to the Provincial Governments in Canada," when he states that, "If the Dominion desires certain services to be developed, with common standards in all the provinces, and if these services cannot be handled by direct expenditure through its own officers, it ought to give conditional and not unconditional subsidies to the provincial governments."

Mr. McCann moved that the report of the Subcommittee be adopted.

Mr. Wright stated that due to the fact that the Dominion Government controlled the fiscal policy of the country the provinces were frequently unable to carry out programs in fields over which they had control.

Mr. Maybank stated he wished to have included in the Report of this Committee as a rider or recommendation the following:—"The opinion of this Committee is that the provinces should be free to decide who or what persons may be used and paid in rendering the services provided under this Act."

Further discussion was postponed.

The Chairman introduced Dr. F. Cyril James, Principal of McGill University, who was examined and retired.

On motion of Mr. McIvor a vote of thanks to Dr. James was unanimously passed and was tendered to him by the Chairman.

On motion of Mr. McCann the Committee resolved to ask leave to sit while the House is sitting.

The Committee adjourned at 1:15 p.m., to meet again at the call of the Chair.

TUESDAY, July 18, 1944.

The Special Committee on Social Security met this day at 4.00 o'clock, p.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Bruce, Cote, Fulford, Gershaw, Hurtubise, Macmillan, McCann, McGarry, McIvor, Warren, Wood and Wright.—12.

In attendance were:—

Dr. J. J. Heagerty, Director, Public Health Services, Department of Pensions and National Health;

Mr. W. G. Gunn, Departmental Solicitor, Department of Pensions and National Health;

Mr. A. D. Watson, Chief Actuary, Department of Insurance;

Mr. S. B. Smith, Dominion Bureau of Statistics;

Mr. R. B. Bryce, Financial Investigator, Department of Finance.

Consideration was resumed of a motion made at the last meeting by Mr. McCann "That the report of the Subcommittee be adopted". The question being put, it was resolved in the affirmative, on division.

Mr. Maybank's request at the last meeting, that the Report of this Committee include a rider or recommendation stating that the provinces should be free to decide who or what persons may be used and paid in rendering the services provided under this Act, was discussed and will be further considered at the next meeting.

Mr. Gunn was called and examined.

On motion of Mr. Warren the Chairman was authorized to draft a report for the approval of the Committee, and to include therein recommendations respecting certain phases of social security, other than health insurance, referred to in the Marsh Report.

The Committee adjourned at 5.05 p.m. to meet again at the call of the Chair.

J. P. DOYLE,
Clerk of the Committee.

MINUTES OF EVIDENCE

HOUSE OF COMMONS,

July 13, 1944.

The Special Committee on Social Security met this day at 11.45 o'clock a.m. The Chairman, Hon. Cyrus Macmillan, presided.

The CHAIRMAN: Mrs. Casselman and gentlemen, we have the privilege of having with us this morning Dr. F. Cyril James, Principal and Vice Chancellor of McGill University, and Chairman of the Advisory Committee on Reconstruction. The committee appreciates very much your coming here this morning, doctor, because we know how busy you are with your multifarious duties. Dr. James has been spared the problem of preparing a brief or statement, but he will be glad to answer questions, and I can assure him that he is speaking to a very cordial and friendly gathering. I shall ask the minister, Hon. Mr. Mackenzie, to open the proceedings with some questions.

Dr. F. CYRIL JAMES, called.

Hon. Mr. MACKENZIE: Mr. Chairman, Mrs. Casselman, gentlemen, I wonder if I might be allowed two or three minutes to refer to our first meeting of this committee on the 16th of March, 1943, as we are now nearing the end of our labours, and I think, possibly, Dr. James might appreciate some of the background of our discussions. I quote:—

I might say we have three problems before us: first, the practical and constitutional problems of unification of our existing social services and pension schemes; secondly, the additional measures necessary to give us a complete coverage necessary of the various hazards; thirdly, a survey of the adequacy of the rates of benefit under our existing schemes.

Dealing first with the practical, as distinguished from the constitutional aspect of unification of existing services, this committee might profitably institute enquiry on the following points:—

What measures would be necessary to unify the several provincial workmen's compensation schemes and systems of mothers' allowances?

What measures would be necessary to combine in one plan the treatment benefits accorded by workmen's compensation and health insurance?

What measures would be necessary to combine in one plan the cash benefits under workmen's compensation and unemployment insurance?

What measures would be necessary to adopt a single system of collecting contributions for unemployment insurance, workmen's compensation, health insurance and old age pensions?

Under the second heading this committee might institute enquiries as to the need, the cost and the best method of augmenting Canada's existing social security measures by the various benefits covered in the Beveridge report, such as health insurance (with respect to which a comprehensive report has already been prepared for the consideration of this committee), maternity benefits, death benefits, widows' pensions, and family allowances.

We might profitably also consider how best to proceed about converting our present old age pension plan into a contributory scheme.

We might institute an enquiry into the best method of putting pensions for the blind on a scientific basis, having greater regard for the

medical treatment factor. In this connection again much useful departmental work has been done, and I hope to be able to lay a report before this committee later on.

The third heading for our researches in this committee is as to the adequacy of our existing rates. This would involve a scientific study of the elements of a minimum subsistence standard. I would suggest that such a study should, on account of the fluctuating value of the dollar, be related to the concrete elements of subsistence, rather than to their monetary value. It would be of advantage if the system of measurement could be keyed to the existing well established "cost of living index", so that periodical variations in the price level could be followed through a well understood standard of measurement.

Then again having regard to the wide variations in climate, natural resources and social conditions in various parts of the country this study might take into account the differing requirements of residents in the maritime provinces, Quebec, Ontario, the prairies and British Columbia.

Account might be taken of the varying nutritional requirements of working adults, children and the aged.

Account might also have to be taken of the comparative rigidity of the rent factor in subsistence; and of the wide difference between rents in urban communities and in semi-rural environment.

This is a problem that Sir William Beveridge deliberately put to one side without attempting to offer a solution.

The value of such a study in determining the correctness or otherwise of our existing various scales of grants, allowances and pensions under Canada's present social service legislation needs no emphasis, if we are to try to put our whole social security system in Canada on a comprehensive and adequate basis.

Then lastly, if we are to consider the question of unification we should have to face up to the constitutional problem that would be involved, both with regard to the security measures now in effect and with regard to those that will be required to fulfill our objective of complete coverage. In this connection, however, we should not overlook the possible advantages of further development of the technique of federal grants in aid, as already employed in connection with old age pensions.

The ultimate constitutional solution, if changes are deemed to be required, would probably be beyond the powers of this committee to recommend, except in a purely suggestive way. Constitutional change of major importance would probably have to be the subject of a dominion-provincial conference. The task that confronts us is thus exceedingly broad and complex.

If we were starting from scratch, we might seek in Canada to establish all our social security measures under one authority, with one single contribution, and one central administration.

Or, if we already had a complete coverage of the social security field by partly dominion and partly provincial legislation, we might with advantage have a constitutional conference with a view to determining whether or not we could agree upon unifying the existing structure.

As it happens, we are not in either of the positions that I have described. We have only partial coverage of the field, and the administration is divided between the dominion and the provinces.

Unity and simplicity of administration are ideals at which we should aim. The advantages are too obvious to need emphasis.

Unification, however, presents far greater problems in Canada than in Great Britain, and will take much longer to achieve.

The ground that I have just described as having to be covered if Canada is to adopt anything like the full scheme called for in the Beveridge plan was referred to the committee on reconstruction by myself, with the request that a survey be made.

The results of that survey are contained in the useful and informative report written by Dr. L. C. Marsh, which I tabled at the outset of my remarks.

It is hoped that this report may serve as a means of giving direction to the further and more exhaustive studies which would undoubtedly be necessary as a foundation for legislation.

If we are to do something practical and useful for the people of Canada quickly and effectively, it may be more to the point if, for the time being, we concentrate our efforts on filling out the gaps in our existing social security system.

That is laying the base for our discussion here, over a year ago, and also having regard to the first committee meeting of the advisory committee on reconstruction of which Dr. James was the chairman, in March of 1941. I drew up at that time a directive for the linking up of the work of the two committees, with regard to what might be the studies of the advisory committee on reconstruction: first of all, in the international field, a forecast of a possible international system: will it be collective security, based on collective force and collective preparedness, and not alone on collective idealism?

What will be Canada's part therein? If this is a war for world leadership, what is to be the governing ideal? Is it in social security? What are the principles governing real social security?

Then I refer to President Roosevelt's three cardinal principles of social security for the family: decent homes to live in; development of the natural resources of the country so as to afford the fullest opportunity to engage in productive work; safeguards against the major misfortunes of life which cannot be wholly eliminated in this man-made world.

Then I refer to the Social Security Act, dealing with three of these, which covers: unemployment compensation, old age assistance and old age benefits, security for children, aid to the blind, extension of public health services, vocational rehabilitation.

Then I come to the problem in Canada; the problem of demobilization with respect to the armed forces; the digest of measures already taken and measures proposed to meet this situation; then the auxiliary forces—how they are to be absorbed; then the controls to be maintained—how many of the basic features of the War Measures Act must be retained during the reconstruction period under, say, a Reconstruction Measures Act. For instance, would it be wise from a national and economic angle to maintain exchange controls, price controls, etc.; would it be wise for Canada to obtain a five- or ten-year plan from all the provinces of public works, projects and developments in order of priority, which are deemed necessary as provincial undertakings? Or would it not be wise to obtain from the federal government departments, such as Public Works, Mines and Resources, Transport, Finance, a similar plan outlining reconstruction projects such as public works, reforestation, youth training, tourist highways, etc.?

These submissions should then be grouped under three headings:—

- (a) those definitely provincial and municipal;
- (b) those definitely federal;
- (c) those definitely joint undertakings.

Housing should have a very foremost part in any such submission.

How should social security measures necessary for reconstruction be financed, and how many of the controls and methods of war should be brought into the years of reconstruction?

Now, Mr. Chairman, the committee on reconstruction finished its work some time ago, and I have before me here the main report which is a very overall wonderful document deserving of study: a report of our committee on agricultural policy, a report of the committee on the conservation and development of natural resources; a report of the committee on publicly financed construction projects; a report of the committee on housing and community planning; a report of the committee on post-war employment opportunities, and the post-war problems of men and women.

That is the work that has been done under the direction of Dr. James since that day in March, 1941; and I feel, without the slightest reservation, sir, that the thanks of this committee, of the government and of all the people of Canada are due to Dr. James for the work which has been done.

That leads up to just one question dealing with what has been done by this committee for the last two years on social security and the report of the committee on reconstruction under Mr. Turgeon, considering the various reports—Dr. Heagerty's report, Dr. Marsh's report, and these splendid documents here which came from the advisory committee on reconstruction. Now, what is the greatest necessity for the moment? I referred the other day in this committee when Dr. Davidson was before it to the concluding recommendations in Dr. Marsh's report, and since then Dr. Davidson has submitted to us his idea of priorities in regard to a complete, integrated, composite, comprehensive national structure on social security, and he lays them down here as follows: first, a full employment policy; secondly, development of adequate minimum wage legislation geared to a decent standard of living; thirdly, family allowances, social security insurance and social security pension insurance; then, specialized social health and welfare services.

In response to a question by myself, on page 305 of this committee's reports, he gives the detailed priorities as follows:—

1. Maintenance of the fullest possible measure of employment;
2. Establishment of adequate minimum wage levels;
3. Children's allowances;
4. Health insurance;
5. Old age retirement insurance;
6. Survivors' insurance;
7. Strengthening and extension of the unemployment insurance scheme.

My question to you, Dr. James, is: if you cared to comment on this would you agree in general with Dr. Davidson's recommendation to the committee in regard to the order of priority, to complete the work that has been done by the parliamentary committees, and by your own committee in the last two years?

The WITNESS: Mr. Chairman, I had not seen Dr. Davidson's order of priority until this morning, and my immediate reaction is that the strengthening and extension of unemployment insurance is placed too low in his list. He puts it down as the very lowest item in the picture, and I think that in the immediate post-war situation, when temporary unemployment is apt to be a serious problem, it ought to come very close to the top.

I wonder, Mr. Chairman, if I might take a couple of minutes to focus the problems of social security against the broad background of all our reconstruction problems. The central problem that we shall face after the war, in my opinion, is that of insuring that all of the people who are able and willing to work are enabled to obtain jobs at the earliest possible moment. There are two reasons for that opinion: first, that unless we produce in Canada a national income very much higher than anything we had before this war began we cannot

possibly attain the social ideals discussed by this committee and the Advisory Committee on Reconstruction; secondly, that no scheme of social security or government assistance is as good for the morale of the individual as the realization that he has a useful part in the life of the community and is earning his own living in the way he wants to earn it.

The Advisory Committee on Reconstruction envisaged a three-pronged attack on that central problem of employment. First, there must be a broad series of projects that I need not go into this morning, by means of which private industry and private agriculture would reconvert their facilities promptly at the end of the war with a view to providing jobs and with a view also to providing the kind of goods that we shall need in the post-war period.

In the second place, we need a comprehensive program for the development of our natural resources in a fashion that would increase the wealth of this country. I am using that phrase "development of natural resources" in a very broad sense. We have not yet, in this Dominion, adequately surveyed our soil, our mineral resources or our forest resources; and I am told that if we proceeded continuously at the average rate of progress from 1929 to 1939 it would take about six hundred years to complete a detailed and authentic survey of all the resources of the Dominion. We cannot wait six hundred years—at least not those of us around the table to-day. The first step is that of gathering the data. When we know what our natural resources are, we shall need to plan in greater detail in order to manage and utilize those resources more effectively. But there are also human resources to consider. We must provide housing accommodation for our population, and that means something like 700,000 units in this country during the next ten years. We need to provide a better community environment for those houses, we need roads and rural electrification. That list can be prolonged, indefinitely, but all of these items are included in that comprehensive program for the development of Canadian resources in which the dominion, the provincial and the local governments must work together in developing long range plans that can be carried out after the war. Such plans will be needed to provide employment, but they are also needed to enlarge and maintain the national income during both the immediate and more distant future.

There remains the third prong of the trident: a program of social welfare designed to raise the physical, mental and cultural level of the Canadian people, Canada) the prospect of attaining the maximum development of which they are capable in terms of biological and mental factors. Biology is not democratic; people are not born with equal abilities, but we can go much further than we do at present in the direction of ensuring that every child will have a chance to give to every boy and girl in Canada (and indeed every man and woman in to develop to the maximum of his potential.

Such a broad program of human welfare involves, first of all, the maintenance of public health. I am not at the moment stating the items in order of priority; I am simply stating fundamental principles. The protection of public health, not only in the sense of giving medical care to the individual who happens to be sick, but in the much broader sense of ensuring that everything possible shall be done to prevent the development of sickness, is absolutely essential. This involves among other things, careful consideration of housing, of water supplies, of sewage disposal and human nutrition, as well as bacteriological and epidemiological research. It also involves an improvement in our educational system that raises such constitutional problems, but I am stating the problem for Canada as a whole, and not simply defining a dominion government responsibility.

Human welfare also involves the comprehensive problem of social security insurance and social security, which is the special responsibility, Mr. Chairman, of this committee. The purpose of any program of social insurance is to

redistribute a part of the national income. We should not try to convince ourselves that social insurance increases the national income to any substantial extent; it may, in a very small area, mitigate the severity of cyclical depressions, but there is no evidence that social insurance increases the national income measured in terms of goods and services produced except in the very long range sense that if we educate every child more satisfactorily, and maintain more effectively the physical health of both adults and children, we shall avoid the losses that now result from ignorance and disease. These are not small losses. If we measure time in generations of human life, an efficient welfare program can have a profound effect upon the national income and national well being of Canada, but for the moment we are considering the immediate post-war years, a much shorter period.

For such a short period, we must study social insurance as a technique of redistribution. It takes income from those that have it in abundance in order to give to those who are less well off. We must therefore keep in mind continually one fundamental question, how much of the national income can reasonably be taken for the purpose? That question must be answered clearly before individual rates of benefit are determined and various types of coverage provided. We know that the risks that are insured against are serious. We know that a sound scheme of social insurance maintains the physical welfare and moral stamina of the individual if it is well administered, so that a perfect solution of this problem demands the careful balancing against one another of both economic and sociological considerations.

Obviously the problem cannot be solved, *in vacuo*, by threatened arguments. It might, for instance, warm our generous impulses to give everybody in the community an annual income of \$5,000; but that is impossible in terms of present goods and services. Our national income in Canada during the immediate post-war period is the growing factor and in any social security scheme we have to correlate our progress with the situation in industry and agriculture as it exists at the present time. The purpose of social security is not to discourage employment; it must be designed to supplement the opportunities for employment in the case of those individuals who, through no fault of their own, are unable to earn their living.

Approaching the problem from that angle, and recognizing, as the Prime Minister pointed out in the House a few days ago, that at the end of this war Canada will face the problem of finding jobs for roughly 2,000,000 people, the first desideratum, to my way of thinking, is to develop a comprehensive unemployment insurance program that will take care during the months required to transfer from one job to another of any individual who is let out of a job in war industry because that industry is closing down, or any individual who comes from the armed forces under the provisions of P.C. 7633.

Second in order of priority, I would be inclined to place public health in the widest sense of protecting the health of the community. Those two things are essential to meet the immediate post-war situation.

Third, there is the broad group of proposals involving the maintenance of family living standards, including the provision of children's allowances. I would point out, however, that the payment of children's allowances is only one way of tackling that problem. You can maintain the health of children and the well-being of the family by cash payments; but you can do the same thing by providing adequate assistance in other forms through ordinary governmental machinery. You could provide free meals at schools (especially in rural parts of the country); free hostels which may become necessary because of the difficulties of transportation in thinly populated areas. By such measures the amount of cash that may be needed under a program of children's allowances would be greatly reduced, and for that reason I prefer to regard

the question of the maintenance of family income as a broad question that can be tackled through any one of several ways, or a combination of them.

Those three, unemployment insurance, public health measures, and the maintenance of family living standards, seem to me, Mr. Chairman, to be the most urgently needed items of social insurance, but I do not have any strong feelings as to the relative priority of the other items.

By Mr. Fulford:

Q. To what extent did the British parliament discuss the proposals outlined in the Beveridge report, and how many, if any, of those proposals have been recommended, or have any been actually implemented?—A. I am afraid I cannot answer that question authoritatively. Up to a few weeks ago none of them had been implemented, to the best of my knowledge; they have been discussed.

By Hon. Mr. Mackenzie:

Q. There is a white paper?—A. Am I correct in saying that they have not been implemented?

Q. That is correct.—A. They have been discussed on the basis of appropriate modification of the scheme that is now in practice, and a white paper has been issued.

Mr. MAYBANK: The white paper has come along within the last ten days.

Hon. Mr. MACKENZIE: Yes.

By Mr. Bruce:

Q. I would like to ask Dr. James if he knows whether Great Britain has adopted a system of family allowances?—A. To the best of my knowledge, no, sir.

Q. Secondly, I would ask Dr. James if he thinks there is any method of assuring that money voted this way will reach the children, or is there not a chance that it may be dissipated en route?

The CHAIRMAN: I do not think that is a fair question.

The WITNESS: I would like to make a comment. I am no more able than the next man to guarantee that if you give money to John Jones it will be spent in the way you want it spent, but I have faith in family affection and loyalty. Although there is no family allowance system in Great Britain, the British government, during this war, and in spite of everything, has carried out a magnificent program for the care of children's health. The provision of free meals at school has been properly worked out, together with the provision of free milk for all families that have children, and the provision of free holidays for families that are not able to send their children to the country. This program has literally worked marvels.

While it is perfectly true that you can hear gossip in London, and probably find actual examples of families that have traded the milk ration to somebody across the back fence for a ration of gin, the over-all picture shows that there has been an increase in the height and weight of the children in slum areas during the war, in a period of air raids and many other hardships, when there is every reason in the world to expect that physical deterioration would have occurred. The record of the improved health of these children during the past four years is ample testimony to the fact that these schemes do actually work. I will add one further point that should be kept in mind: the local community, which we have sometimes under-estimated in Canada, is a very powerful political conscience for each individual within it. If these matters are administered through a local organization composed of local citizens who are familiar with the habits, the aptitudes and the abilities of the people with whom they are dealing, the possibility of diverting funds from the purpose for which they are provided would decrease very sharply from an initially low level.

By Mr. Bruce:

Q. In order to clarify further what has been said, I take it that Britain does not give a cash subsidy but gives additional nutritional services? I recall a tour through England fifteen years ago and they were providing nourishment for the children in the schools, and it is a fact that in this war, I think, 80 per cent of those men who have been called up have been fit for service whereas in the last war the figure was 33 or 35 per cent—I am not sure of the figures. But there is an added feature. Would you feel that by increasing our social services nutritionally to everybody throughout the country so that children could get the advantage, as well as food and housing, and so on, that might not be a better way of meeting the situation than by cash bonuses?—A. I am perfectly willing to admit that the two are interchangeable to a very large extent, as I suggested a little while ago, but I am not sure that you can entirely replace the cash allowances by such things as low-cost housing, rural electrification, free meals at school and free hostels in thinly populated areas. By means of such provisions as these you can reduce the cash bonus to a very low level; but I am not convinced at the moment that you can completely eliminate it in the case of large families. That would be my tentative judgment, but I am open to conviction when a detailed scheme has been worked out for the provision of such material assistance.

By Mr. Maybank:

Q. Do you know whether in any place where there are cash family allowances they have had occasion to look exhaustively, after the operation of the Act, into the problem posed by Dr. Bruce, and whether they have found any difficulty such as has been suggested by Dr. Bruce might be the case?—A. No, I do not. The only two examples of children's allowances with which I am familiar are the New Zealand scheme and the British Unemployment Insurance scheme (which pays a supplementary bonus for children if a man is out of work). In both of these cases, while it is necessarily recognized there may be diversion of the funds in a few instances, the general feeling is one of satisfaction. There is no suggestion of abolishing the plan, so far as I have heard.

Q. There would be this difference between the two allowances to children, the one under unemployment insurance and the one under family allowances, that in the latter case it is always paid to the mother and in the former case it is paid to the unemployed person? A. Yes.

Q. We try to guard against that by giving it to the wife.

By Mr. Gershaw:

Q. I wonder if Dr. James will give us some suggestions as to how the national income can be kept? For instance, a large portion of the population depend on markets for farm products, prices for farm products, and farm income, and it seems to me that we have to plan to keep this income or we will not be able to spend it. Could you give us some idea along those lines?—A. That is a large subject, Mr. Chairman. I will try to present my opinions in skeleton form and, perhaps, if I do not touch on any aspect of particular interest, you will be good enough to ask specific questions. I pointed out a little earlier that, in the opinion of the Advisory Committee on Reconstruction, we shall need a national income of seven and one-half billion dollars in round figures (at present levels) in order to maintain a decent standard of living in Canada and reasonable prosperity after the war. That figure is more than twice the greatest pre-war national income that Canada ever produced, but it is 10 or 15 per cent less than the national income that we are producing at the present time. I need not emphasize the obvious fact that it is much easier to increase the national income during a period of war than in times of peace, for the simple reason that the dominion government is during a war the largest purchaser

and there is an unlimited market for many standardized goods which are fairly simple to produce once the factories are organized. It is not as easy to maintain production after the war. The demand for goods, if we are still thinking in terms of a free and democratic country, is intensely varied by the diversity of human tastes, geographic, professional and personal. The production of such a variety of goods raises all sorts of local problems and technical problems, so that it is essential to encourage every business enterprise, whether it be the small local shop that employs five men or the larger corporation that employs five thousand, to go ahead as rapidly as possible with its plans for the production of the things for which it is qualified. I do not think the government can do very much toward the reconversion of private business, but the Minister of Finance has facilitated the process, in the present budget, by permitting deduction of the costs involved in planning. Government fiscal policy can go further by appropriate variation of the rates of deduction from taxable income that are allowed for obsolescence and depreciation, as well as by varying rates of taxation on corporation profits. I believe that both of those ideas were suggested a decade ago by Mr. Dunning when he was Minister of Finance.

The purpose of such a policy is to encourage business expansion during those periods when we need business expansion, and to discourage it during a period when there is danger of a runaway boom. In round figures, the best economic analyses available in this country—as well as in the United States and Great Britain—suggest that, to maintain a high level of prosperity, the country needs a total investment (i.e., expenditure on capital goods as distinct from consumption goods) of about one-fifth of its national income. If, therefore, the national income of which we are thinking is seven and a half billion dollars a year, we should need an annual figure of total investment amounting to one and a half billions.

It is highly improbable, however, that business enterprises will arrange, by coincidence, each year for exactly one and one-half billion dollars of investment, and it is for that reason that the second prong of reconstruction policy involves governmental (or public) investment at appropriate times and in appropriate amounts on projects that are directly useful to the community. Such projects may be useful in the narrow financial sense, as in the case of the preservation of our forests, the discovery and utilization of our mines, the improvement of our ports and harbours, the provision of appropriate housing accommodation and rural electrification. They may be unprofitable in this sense but profitable in the widest sense of social and esthetic humanism, when we are considering the beautification and care of our countryside, provision for recreational space, improvements in educational facilities and expenditure necessary for public health. By a combination of private initiative and public investment I am confident that Canada can maintain a satisfactory line of national income, and I shall be glad to answer further specific questions, rather than take up time to discuss each of these problems in detail.

Mr. McCANN: For how long can Canada maintain this income of seven and a half-billions?

The WITNESS: Indefinitely. We have, however, omitted one specific problem that complicates the picture, and that is Canada's relationship to the rest of the world in terms of international trade, a problem that has always been of acute importance to Canadian agriculture, to Canadian forest industries and to Canadian mining industries.

I do not think that international trade presents very much of a problem in the immediate future, by which I mean the period of five or ten years after the war. (I do not pretend to have any long-range prophetic vision.) I do not think there is going to be much of a problem in Canada's food-producing industry during this immediate post-war period. If we are going to play the

part that this Dominion should play in the rehabilitation of the rest of the world, in accordance with the ideals of our Prime Minister and other international leaders, we may have to *increase* our food production. I am informed by agricultural economists that there is not, throughout the whole world, at the present time (and was not prior to 1939), enough food produced to provide a decent standard of living for the population of North and South America, of Europe and Asia, even if we were anxious to provide it. We and our allies must supply the needs of something like 300,000,000 people in German-occupied Europe and about 400,000,000 people in Japanese-occupied Asia. If we really mean what we say about raising international standards of living, it may be necessary for this country to lend capital funds in substantial measure. A good deal of these capital funds will be spent on buying food to feed labourers who are erecting new equipment in the borrowing countries, and Canada must export that food so that I am not inclined to feel that our immediate post-war agricultural problems will be critical if the UNRA scheme develops and Canada participates in it.

After that two or three years, the agricultural situation might become critical. The other countries of the world will have restored, in large measure, their agricultural productivity. They may still need certain Canadian supplies, but the extent of their demands will be reduced. We should, however, bear in mind, in trying to appraise that secondary period, the fact that the agricultural population of this country has shrunk sharply during the present war. If we measure it in terms of age groups, the number of young men and women on the farm has shrunk even more sharply and output has only been increased as a result of incredible improvements in agricultural efficiency. Our farmers are, at the present time, producing more food than they have ever produced, with a smaller manpower, and I do not think it is reasonable to suggest that after the war we should give up that progress. One of the ways of raising the standard of living on the farm is to increase, as we have done, farm productivity. If that trend is maintained, if we are going to have a smaller number of farming families, operating with more equipment and greater efficiency, in order to supply the needs of a greatly increased industrial population, we are going to find that our domestic consumption of agricultural products is very much larger in proportion to the total output than it was before the war, and that the importance of foreign markets for our basic products is going to be less in the ten years after this war than it was in the ten years after the war.

By Mr. Wright:

Q. Your reply to one question was that the first consideration after the war is to see that we have employment and that that employment must be based on the natural resources of the country and the demand for those resources. I would like to ask you if you think that in the past we have had an intelligent development of those natural resources? I mean by that, first, with respect to their best use for the people of Canada as a whole, or rather, have they been developed for purposes of obtaining the greatest immediate return, whether they were used in Canada or exported from Canada? Has not that been the basis of the development of our resources to date? Secondly, with respect to conservation of those resources, under our present set-up have we in the past made any attempt at conservation of our resources, or rather in our forest resources have we not put our best into where we could get the quickest return and make the most money whether we use those resources at home or export them—the amount of work to get a quick return—and the same is true with respect to our mining resources. We open a mine up and we take the best ore out by the quickest method we know rather than having any long term policy with respect to the conservation of those resources?—A. By and large I think it is true that Canada has not had a conscious national policy for the

conservation of its resources. The extent to which the exploitation has been scientific has been dependent very largely on the wisdom of the concern that was exploiting the resources. Some of the larger concerns, with long-range vision, have proceeded more scientifically than some smaller concerns that have not had enough capital and have gone in to take out what they could get. But it should be remembered, in making this generalization, that in every country throughout the world, until about twenty years ago, there was an assumption that natural resources were unlimited, and that the development of those resources could be carried out without any thought for the future. The whole concept of resources as a wasting asset, and the planning of their use in such a way that the wastage is minimized, is really a development of the past two decades on this continent and in most of the European countries. To-day we are conscious of the responsibility for developing for the whole of this Dominion a more comprehensive and scientific policy than any country has ever had—even Sweden which is always talked about as though it were perfect in this particular regard simply because it has been wiser than most of the nations.

Q. Have you any answer as to how we in Canada can conserve these things?—A. Very definitely. If you will permit me to ignore for the moment the legal question of dominion and provincial rights, since that is a legal and not an economical problem—the first step is to complete as rapidly as possible a detailed survey of the whole of this dominion—a survey in terms of forest cover, of mineral resources, of the quality of our soils—and at the same time to survey our rivers, our lakes and our seaboard. Such a survey is simply the collection of facts, but these facts are the necessary basis of future policy. In regard to mineral resources which cannot be replaced, we are confronted with the need for devising a plan that would utilize them in the most economical way possible, and it might be well to study carefully the extent to which Canada could profitably *import*, rather than *export*, mineral products. In the long view, that country which imports its mineral products from abroad, and conserves its own assets, is probably following the path of wisdom.

With regard to forests there is a vast body of information available, for instance, in the hands of the Dominion Forester. Silviculture has developed into a recognized science, so that there is no argument about the best methods of first conservation. But the application of silviculture requires a larger expenditure of funds and it is necessary to take hold of that matter immediately. I am informed that the Russian government, in spite of being heavily engaged in this war, has taken steps to reduce forest fires and has reduced them by more than 50 per cent since the beginning of this war. In and above fire prevention, we need better administration of our forests and of our streams, both to protect the wild life and to remove the menace to life and health which results from such carelessness as the present methods of sewage disposal. It should also be remembered that forests and streams are a cash asset in Canada's vast tourist traffic. In the Manitoba development for the conservation of fur bearing animals in the marshes at the lower end of the Saskatchewan river, there is a successful example of what can be done by a single province, an experiment that offers one of the few practical answers to the problem of the Canadian Indian.

These are broad outlines of steps that need to be taken in the various departments of government in this country and by the various private organizations.

Q. Would you say that we cannot get along, as in the past, allowing the exploitation of our mining resources for immediate gain—that we have to plan for something further than that? Can that planning be carried out by private enterprise, do you think?—A. I think private enterprise can do a tremendous amount toward it.

Q. They have not developed it intelligently in the past. I am wondering whether it can be developed intelligently in the future without certain controls?—A. The over-all problem of planning for conservation is a government matter; it is not a matter for private enterprise. My personal view is that the Dominion and provincial governments, when they have completed their survey, will have to say how far they are willing to have various areas developed at a given time. That is necessarily a public decision. But in the development of those areas I doubt very much if the government can improve on the efficiency of operation shown by the best of our commercial companies.

By Mr. McCann:

Q. Do you agree with what has been suggested by Mr. Wright, that the development of the natural resources of this country has been for private gain rather than for the needs of the country?—A. No, I did not say that. I said it was not based on long-range planning for conservation in the interest of future needs.

Q. What we have heard in the last few minutes is interesting, but I suggest that it has been a discussion of reconstruction rather than of social security in which we are perhaps more particularly interested. Now that this country has embarked upon an ever-broadening program of paternalism, one of the personal objections which I have and which I hear from a good many people is the numerous methods by which the contributions have been collected and will continue to be collected in order to put social security measures into effect. Now, it has been suggested that if this country were starting from scratch that that would not be as difficult a matter as it is to-day. Of course, no country has started by a process of evolution in bringing these different measures into effect. Would you suggest to the committee any method whereby we might have the unification of the collection of the different things which will be required in order to put the social security measures which we have in contemplation into effect? For instance, an objection we hear from the worker is that he has one deduction for unemployment insurance and another one levied for the contributory system of old age pensions, and we will have a multiplicity of deductions at that time. Have you any suggestion to make with reference to a single system of collecting these different contributions?—A. Well, the answer to that is very simple in terms of theory, because the difficulties are all difficulties of jurisdiction and of parliamentary policy. The logical and clear-cut ideal of any individual who has approached this problem with an open mind would be to suggest a single deduction. There is the New Zealand system. Such a standard deduction (which need not necessarily be the New Zealand 5 per cent) would be levied impartially on every recipient of income. It is easy to collect, because it means that every income payment must have that percentage deducted from it, whether it represents interest on bonds or a salary cheque or a dividend. That arrangement has everything to commend it, in my opinion. It means that the individual contributes, in proportion to his ability to pay, to what is after all a social responsibility. I should like to point out, however, that while I favour simple and centralized collection of contributions, I am strongly in favour of local administration of any scheme of social insurance. I should feel very much worried if we were to develop in this country a completely centralized government organization which was going to attempt to decide on the exact need of each family in every township that was seeking assistance, a bureaucracy that was going to decide whether or not John Jones was entitled to have health benefit continued for an extra three months or Mrs. Brown to receive a widow's pension. Decision on matters of this kind must be in local hands, and many types of local organization are possible. I confess that one scheme that I have heard proposed appeals to me very much. It provides for the creation of local committees of seven members for appropriately defined

regions within each province, such committees being composed of three people elected by the citizens of the region, two prominent citizens of that region nominated by the provincial government and two other members, who need not be local citizens but would be experts nominated either by the provincial or dominion government. A scheme of that kind which gives the administration power to the local committee and makes such a committee responsible in part to the local citizenry is a method that has great possibilities.

By Mr. Mayhew:

Q. Great emphasis has been placed upon reconstruction and rehabilitation and on the part that industry should play. I notice that you have laid emphasis to-day on that. I am thinking at the moment that Canada industrially is pretty well taken care of. The newsprint industry, for instance, is quite capable of producing all the newsprint that we can use or export; the farm machinery people are capable of producing all the farm machinery that is needed. Probably the same thing is true with regard to radios and washing machines and many other things that I could mention. Speaking along that line, then, what would you suggest that industry could do to further increase so as to take up this supply, to re-employ the men coming back from overseas?—A. That question requires a good deal of careful analysis if one is going to appraise each industry; but from various examples that I have run into during the recent past, there seem to be substantial possibilities of development in the chemical industry. There is also the whole area of the building industry, and by the building industry I am not referring to the contracting industry alone, but to the provision of new wall materials, floor materials, electrical installations, etc. If my memory is correct, less than 10 per cent of the houses in Canada, outside of large cities, have any electricity at all at the present moment; and if you think in terms of hot water heaters, refrigerators, radios, washing machines and so on, you have a tremendous number of those things that will be in great demand if we are able to develop the kind of society we are talking about. The clothing industry would have quite a large job to appropriately clothe the people of this Dominion. There is the telephone industry; the television industry; the production of synthetic fabrics of one kind and another. There is also the furniture making industry. These are a few of the industries that come to my mind. I might say that every one of the industries that I have been in touch with during the last four years has been developing plans for reorganizing and extending their activities over what they were in 1939.

Q. That answers the argument to an extent; but would that not require again a good deal of research that at the present time we are not ready for, such as using our waste material going into the building trades, the use of the waste products from the sawmills and the pulp mills—that could be used in boards—and there is also the matter of the development of the fertilizer; are we ready for that? Have we done enough research work to carry on with that immediately after the war is over?—A. I would say definitely, that a great deal of research is being carried out along these lines. There is a tremendous amount of chemurgic research for the utilization of agricultural waste-products. A good many of the pulp and paper companies have carried out extended research in the manufacture of plastics as well as the improvement of their ordinary products. The chemical industry has had a very substantial research program. I know of two of the larger mining companies that have done considerable, and I am sure that in any of our industries in Canada at the present time you will find a substantial amount of research going on.

Q. That leads up to where I hoped you were going. Would it not be advisable for the Research Department at Ottawa to establish a branch in the universities of the different provinces of Canada to enable those who are in the

different provinces to take full advantage of the research field?—A. I am not sure that that is necessary but I have no objection to it.

Q. Canada is a land of great distances, and it is a long distance for some of our people who have to come to Ottawa?—A. I know it is a great distance; I have crossed this country at least once every year since I have been here. The National Research Council to-day is, of course, physically located in Ottawa, but a very large proportion of its work is done not in Ottawa but at the various universities: I do not know one university in Canada, from the university of British Columbia to Dalhousie, which is not in contact with one or other of the research programs now going on. I do not think we would improve research by setting up a branch in each university, but I think we might improve the contact between the research scientists and the general public.

Q. The same thing.—A. On this point I am not immediately clear as to the best procedure, because nothing is more dangerous than appointing a man who is a sort of general adviser on research to a community; he tends to be a salesman and not a good scientist. I think a better way might be to develop in the public mind a recognition of the fact that our several universities are all in touch with the National Research Council, and to encourage business men in Vancouver, for instance, to go to the university of British Columbia for problems that should be handled there with the understanding that if those problems are not solved in Vancouver they will be passed on to the Research Council. I think that the real defect you have in mind which has also worried me, is that business in Canada has not been in sufficiently close touch with science. To some extent, this situation has changed during the war, and I hope that we can maintain close relationships between the business community and all of the universities resting on the foundation that now exists between the universities and the National Research Council.

By Mr. Blanchette:

Q. In your opinion would the child social welfare services suggested by Dr. Bruce be cheaper and as generally effective as cash payments on family allowances?—A. I am not sure that they would be any cheaper. I think that if we were not going to carry out the scheme envisaged by family allowances, it would cost just as much to set up a comparable scheme of direct assistance. Such a plan might be a little more effective in the early stages but, as I said in answer to Dr. Bruce, I think that if the administration is placed squarely on the shoulders of a responsible local committee it is going to be a very hard-boiled citizen who tries to divert the funds to a wrong use after he or she gets them.

By Mrs. Casselman:

Q. I would like to ask whether Dr. James believes that more could be done through the Canadian Broadcasting Corporation to bring the results of research to public attention, than at present?—A. I am quite sure it could, but it is a hard job. I saw in the *Montreal Gazette* this morning, an advertisement by one of the breweries regarding R.D.X. It was a very dramatic description by one of the members of the advertising staff, and I am sure that a lot of people will read it. It takes somebody like the writer of an advertisement to describe research because the research man is seldom able to make an interesting story out of what he has done.

Q. That I think is the only point, that they cannot do it well; but in the press these matters are so condensed that to the ordinary individual it does not mean a great deal. I was wondering if the National Research Council could get in touch with the C.B.C. or if your department at the university could get in touch with the C.B.C. and get some sort of a series that the average person could understand more readily?—A. That is worth trying.

By Mr. Mayhew:

Q. The average business man who has a shop that employs five or ten men is of the opinion that the National Research Council in Ottawa is not interested in his affairs, and it is very seldom that he would ever think of taking advantage of asking for help. Since coming here I have had a good many examples of that, trying to get help for the man in small industries who employs probably a mechanical engineer to help him in his difficulties, and I think if it could be brought to public attention that this department of research here is willing to help these men in their difficulties it would do a good deal of good in helping production all over Canada.

By Mr. Maybank:

Q. I wish to turn to a different branch of the presentation which Dr. James made in his first appearance. You will recall that you remarked with reference to Dr. Davidson's presentation that you would have put unemployment insurance up in the list, and I wondered then just what idea you had in mind with reference to extending or improving the unemployment program of the dominion. Do you mean that we should expand it—take in a larger circle—or that there should be some sort of supplements in certain cases? What do you mean by strengthening the unemployment insurance program? I think you put it about second.—A. I put it first on the list. I had in mind two problems which I think are going to be critical during the immediate post-war period, and will have to be faced by the government at that time. First, there are certain groups in the community that are not at present covered by unemployment insurance, but may be unemployed; secondly, there is the group that is covered by unemployment insurance but includes some members who will be entitled to such a short period of benefit the payments may cease before they find a job.

Q. They would have such a small credit?—A. They would have such a small credit. Those two problems seem to me rather acute. I should prefer not to wait until the end of the war and possible unemployment forces the government to give them a dole of some kind to carry them over. Surely it is worth while exploring the possibility of an unemployment insurance scheme that would be universal, applying to everybody in the country, and defining the period of benefit in standard fashion for all participants. There may be some objection to that from the people already covered under the scheme; they might not want it diluted by bringing others in, and might resent the idea of receiving benefits except in proportion to the payments.

Q. Of course, there is quite a number who believe that grass would have to grow on all of the streets of our cities before they could get any benefits—men of long seniority on the railways and people in executive offices in business and banks. There would, of course, be that difficulty in immediately expanding it and collecting from a larger circle; but whatever the difficulties might be, that is your idea—you would enlarge the circle. In fact, you would make it comprehensive of all and, of course, take any payments up to the present time from them and from their employers. And now, with regard to the others: take the case of John Doe who has not been long at work and, therefore, has not much of an unemployment benefit credit on his line in the ledger. Something would have to be done to supplement that on the reserve that is at the moment earmarked for him?—A. Yes.

Q. Boost the reserve so that everybody would get a certain amount and that amount would be worked out according to the probable needs of the situation, his particular individual service, his personal unemployment problem?—A. I do not know that I would go that far. I am not suggesting changes in the rates at the present time.

Q. No, no.—A. The rates would continue as at the present time and the change that I am suggesting is simply that if John Doe has only been in his

job a short while, so that his credit is small and it is impossible in the light of a general depressed situation for the employment office to find him (or for him to find himself any job) for a period of three months, I think he should be protected up to the end of that three months. The whole idea of social security is simply to take the income from the people who have it for the purpose of giving something to the people who have no other income. That is the basis, and the idea is splendid if it is satisfactorily worked out, but you cannot logically define such an idea in terms of restricted membership and benefits conditioned by contributions.

Q. Have you ever estimated the amount that it probably will be necessary to put in to boost the reserve to take care of the situation as you have suggested? Do you know whether there has ever been any tendency in the employment offices in other places to try to get employed first the chap who is drawing benefits as against the chap who is not drawing benefits?—A. With regard to the second question, I do not know of any experience that would suggest that at all. The chief machinery I am thinking of is the British Employment Exchange, and they are dealing almost entirely with people liable to benefit.

Q. They have not many of the type we have been talking about?—A. Quite.

By Mr. Fulford:

Q. I wonder if Dr. James could tell us what countries have cash family allowances? My reason for bringing that question up is that in my experience in speaking to people in all walks of life I have found them absolutely unacquainted and ignorant of the proposals. I have found people apathetic and in many cases—the majority of cases—hostile to the principle of cash allowances. I have found further that the rank and file of people, especially among the workers, believe that our first duty after the war is to supply adequate housing facilities—that our present housing conditions in Canada are deplorable?—A. On the second half of that question there is no disagreement at all: decent housing is essential. As I have tried to emphasize social security in its broadest sense is one of the prongs in the reconstruction trident and if we enlarge it beyond the other two, the results would be very sad. With regard to the other part of your question I cannot give you a definitive list of countries that have family allowances. I have mentioned New Zealand. They also existed in both Germany and Italy before the war, and they exist in Russia today. I am not sure whether there are any other countries that have cash family allowances.

Q. Were they not proposed in the three Scandinavian countries and turned down?—A. They were proposed. I do not know the ultimate result of the proposal.

By Mr. Adamson:

Q. Dr. James said an extraordinary thing about mining. Now, there is the time factor; the desirability of the time factor is vitally important; and he went on to say that at the rate we are developing our natural resources it would be about 600 years before we got a survey. Do you not think that the making of a survey is of paramount importance with regard to our natural resources, our soil conservation and our forests?—A. Absolutely.

Q. That takes priority over every thing because men are coming out of the army now, and it is a psychological problem there. Now, my second question: you said, sir, that you thought we should very seriously consider the curtailment of the exportation of our mineral resources. In other words, there is the old theory that if you develop a pound of copper you get 8 cents, and if you manufacture it you would get two or three dollars—that extra profit would accrue—but that would require Canada developing more than she has to date, or tremendously as an industrial nation. Your theory would not apply to such precious metals as gold? Our export market for metals has been our main

market. With regard to this question that we are wasting, more is being left in the ground now through our present system of taxation than is being wasted by export. I would like to get your answer to that question of the exportation of metals?—A. With regard to your first question, the survey is, of course, of paramount importance, but it would not employ a very large number of people. It is a technical job; while it must be carried on at once it is not of great importance in the sense of providing employment for large numbers of people.

With regard to your second question, I did not say that we should have serious doubts about any export of our metals. What I think, is that there should be no effort to encourage the wholesale exportation of metals, which is slightly different. In the past this country produced, in the mining field, as large a quantity of metal as we could sell abroad; it was one of our major foreign trade activities. In view of the fact that our resources, although among the greatest in the world, are not unlimited, I think we should carefully explore the whole situation with a view to deciding whether we would not prefer to reduce the extent of our production for export and utilize our available resources in a slower fashion. That might mean a substantial development of domestic industry to take care of our own native products, and it might mean an appropriate taxation scheme. About gold I am not much worried. I do not think gold is one of the most valuable metals for industrial utilization. As long as somebody wants to purchase all our gold from us, and we find its export useful to our balance of payments, I would not discourage this export.

By the Chairman:

Q. Dr. Marsh, in his report at page 115, gives two lists of possible priorities, one taking a long-range view, and the other for the post war period. Do you agree with those two reports?—A. Yes. The order of priority suggested for the post war period was pretty much the one I stated in regard to unemployment, health and children's allowances.

By Mr. McCann:

Q. If we fully implement in the post war period, as is contemplated, an adequate minimum wage legislation throughout the country, how great is the need for family allowances?—A. I do not think that minimum wage legislation solves that particular problem. If you fix wage rates high enough to provide for a family of three or four children, as would be necessary if our population is to effectively reproduce itself and expand to use the resources of the dominion, I think you would penalize a large number of individuals. You would discourage employment, and might also cause the shutting down of a fair number of industries. Such a policy would create a substantial differential in the case of the single man or the married man who has no children. In my opinion, wages should not be fixed on that basis at all. I believe that wages and salaries should be fixed entirely on the basis of the usefulness of the individual, which is one of the fields of thought in which Russia has gone so far ahead of us that you would not find a trade union in the United States or Canada that would be willing to adopt the Russian system of wage payments. I think that wages and family allowances are separate problems and while we would hope in the long run that everybody would have an income to maintain a family reasonably, I think the payment of family allowances meanwhile is necessary as a provision for that intermediate period during which we are carrying through our reorganization.

By Mr. Cote:

Q. I would like to know if Dr. James considers that the constitutional aspect throughout the country is a serious step in the establishment of a uniform, comprehensive and effective social welfare scheme after the war?—A. I cannot answer that as accurately as the members of this Committee. If the people of

Canada really want to carry through a comprehensive scheme, that desire will not be frustrated simply because the provinces and the dominion cannot get together and agree on a workable scheme. If, on the other hand, there are serious differences of opinion among our people, so that different groups have contrary ideas, and some groups are not in favour of a uniform scheme, then a uniform scheme is impossible. As I see our constitution, it is something that is made for the purpose of permitting the governments of the country to carry out efficiently the policies that the people of Canada desire, and difficulty only arises if we have a clash of opinion developing between two different units in the constitutional structure.

Mr. McIVOR: Mr. Chairman, I would like to express appreciation to Dr. James for the fine time he has given us this morning. I say that it has been good for us to be here, and it reminded me of the time I sat at the feet of the doctors and knew what they were talking about. But I wish to express my appreciation to Dr. James for his splendid services.

The CHAIRMAN: Dr. James, on behalf of the committee I should like to express to you our sincere thanks for coming here to-day and for the very illuminating and interesting statement you have given us. I am sure it will be of great worth to the committee when they are making their report.

The Committee adjourned to meet at the Call of the Chair.

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SESSION 1944

HOUSE OF COMMONS

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SPECIAL COMMITTEE

ON

SOCIAL SECURITY

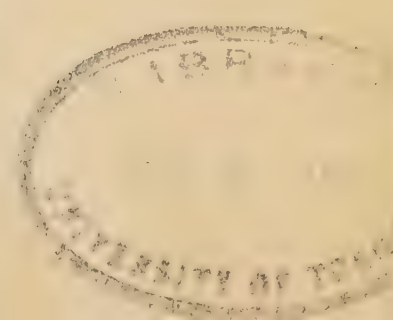
MINUTES OF PROCEEDINGS

No. 13

THURSDAY, JULY 27, 1944

Including
THIRD REPORT AND DRAFT HEALTH INSURANCE BILL

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944



REPORT TO THE HOUSE

JULY 28, 1944.

The Special Committee on Social Security begs leave to present the following as a

THIRD REPORT

After a long and careful study of the subject of Health Insurance, which included the taking of evidence and the receiving of briefs from all interested organizations, your Committee presents herewith a draft Health Insurance Bill submitted by the Department of Pensions and National Health which, with minor amendments, it has approved with the exception of Clause 3 and Schedule 1, dealing with financial arrangements between the Dominion Government and Provincial Governments.

Your Committee recommends that this Bill be referred to the Dominion-Provincial Conference for consideration of its general principles as expressed in its various clauses, and of the financial arrangements involved.

Your Committee heard evidence and received briefs on other phases of social security, but they were unable to give detailed or adequate study to the whole subject, which involves also intricate financial and constitutional problems. Your Committee recommends that when possible, consideration be given to the extension of unemployment insurance, sickness cash benefits, funeral benefits and other measures which will help to provide protection against old age, illness and economic misfortune, and to the establishment of greater co-ordination, and the elimination of overlapping or duplication of existing measures of social welfare under Dominion and Provincial Governments.

A copy of the evidence submitted is appended hereto.

All of which is respectfully submitted.

CYRUS MACMILLAN,
Chairman.

MINUTES OF PROCEEDINGS

The Special Committee on Social Security met this day at 4.00 o'clock, p.m. Hon. Cyrus Macmillan, the Chairman, presided.

The following members were present:—Messrs. Breithaupt, Bruce, Casselman (Mrs.), Fulford, Howden, Lockhart, Macmillan, McCann, Maybank, Nicholson, Veniot, Warren, Wood and Wright—14.

The Chairman read a draft report which the Committee on July 18 last authorized him to prepare. After debate thereon, Mr. Howden moved that the Report be adopted.

This motion was adopted.

Mr. McCann moved that the Report just adopted be presented to the House.

Motion adopted.

The draft Health Insurance Bill submitted to the House with the Third Report on July 29 is printed herewith.

The Committee adjourned at 4.25 p.m. sine die.

J. P. DOYLE,
Clerk of the Committee.

DRAFT BILL.

Fifth Session, Nineteenth Parliament, 8 George VI, 1944.

THE HOUSE OF COMMONS OF CANADA.

BILL .

An Act respecting Health Insurance, Public Health, the
Conservation of Health and the Prevention of Disease.

First reading, June , 1944.

THE MINISTER OF PENSIONS AND NATIONAL HEALTH.

OTTAWA
EDMOND CLOUTIER
PRINTER TO THE KING'S MOST EXCELLENT MAJESTY
1944

8th Session, 19th Parliament, 8 George VI, 1944

THE HOUSE OF COMMONS OF CANADA.

BILL .

An Act respecting Health Insurance, Public Health, the Conservation of Health and the Prevention of Disease.

HIS Majesty, by and with the advice and consent of the Senate and House of Commons of Canada, enacts as follows:—

Short title.	1. This Act may be cited as <i>The National Health Act</i> .	
Definitions.	2. In this Act and in any regulation or agreement made thereunder, unless the context otherwise requires.	5
"Minister."	(a) "Minister" means the Minister of Pensions and National Health;	
"provincial authorities."	(b) "provincial authorities" means the person or body charged with the carrying into effect of any agreement made pursuant to this Act;	10
"qualified person."	(c) "qualified person" means a person qualified to receive the benefits of health insurance;	
"statutory provision."	(d) "statutory provision" includes any provision made by order or regulations having the force of law.	15
Power of Governor in Council to make grants to provinces.	3. (1) Subject to the provisions hereinafter contained and to the special conditions enumerated in the First Schedule to this Act, the Governor in Council may make an agreement with the Lieutenant Governor in Council of a province for the payment to such province of grants for the objects and in the amounts specified in the said Schedule if such province has made statutory provision for the economic and efficient use of the said grants, but in no case shall an agreement be entered into with a province unless such province has made statutory provision for utilizing both the "Health Insurance Grant" and the "General Public Health Grant" specified in the said Schedule.	20 25

EXPLANATORY NOTE

It is considered that in order to facilitate consideration by a Parliamentary or any other Committee, the total results of the study so far given to these subjects might be submitted in the form of a draft Bill.

Amount of Grant, if average cost does not exceed \$.....

(2) If the average cost does not exceed dollars, the amount of the Health Insurance Grant payable to a province under this Act in any year shall be the amount by which the sum obtained by multiplying the average cost by the number of qualified persons in the province exceeds the aggregate of—

- (a) the sum obtained by multiplying twelve dollars by the number of qualified adults in the province, and
- (b) the sum payable to the province under subsection four of this section.

10

Amount of grant if average cost exceeds \$.....

(3) If the average cost exceeds dollars, the amount of the Health Insurance Grant payable to a province under this Act in any year shall be the amount by which the sum obtained by multiplying the average cost by the number of qualified persons in the province exceeds the aggregate of—

- (a) the sum obtained by multiplying the number of qualified adults in the province by the aggregate of
 - (i) twelve dollars and
 - (ii) one-half the amount by which the average cost exceeds dollars, and
- (b) the sum payable to the province under subsection four of this section.

20

Additional sum payable to the province.

(4) Where in any year, the Health Insurance Grant mentioned in subsection one of this section is payable to a province there shall also be payable to the province in respect of such year, a sum equal to the total of the amounts payable by residents of that province to the Receiver General of Canada as health insurance contributions under Part of the *Income War Tax Act*, in respect of the incomes of those residents in the said year.

25

R.S., c. 97.

Definitions. "average cost."

(5) In this section (a) the expression "average cost" means the sum of dollars and cents until such time as the Health Insurance Grant has been paid to more than two provinces for two years and for each three-year period thereafter it shall mean the amount obtained by dividing the total cost of all health insurance benefits in all provinces receiving grants under this Act during the two years immediately preceding the beginning of each such three-year period by the aggregate of the sums obtained by multiplying the total number of qualified persons in each such province at the beginning of each such three-year period by two or by the number of years in respect of which a grant under this Act was payable to the province, whichever is the less;

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45

(b) "qualified persons" means all persons resident in the province who are entitled to the benefits of health insurance; "qualified persons."

5 (c) "qualified adults" means all qualified persons resident in the province who have attained their sixteenth birthday. "qualified adults."

(6) The Governor in Council may make regulations for determining for the purposes of this section the number of qualified persons and qualified adults in any province, the Regulations.
10 cost of health insurance benefits, and the amounts expended by a province for the general public health services set forth in the Third Schedule to this Act.

(7) Pending final determination of the amounts payable to a province under subsections two and four or three and Advance payments.
15 four hereof, the Governor in Council may authorize the making of advance payments if the province in the agreement authorized under this section undertakes to return the amount by which such advance payments exceed the amount actually payable, and such advance payments
20 shall be deducted from the amount of the Health Insurance Grant otherwise payable for the year in question.

4. (1) The statutory provisions as respects health insurance shall be in such terms as to provide health insurance benefits of the standards, under the conditions and for the Extent of statutory provisions respecting health insurance.
25 persons as set forth in "A Draft for a Health Insurance Act" in the Second Schedule to this Act, or substantially in the terms aforesaid, or in such terms as, having regard for all of the circumstances, for the special conditions affecting the province as a whole, or any special
30 areas in the province, may be approved by the Governor in Council as a satisfactory practical measure of health insurance for the province and the Governor in Council may approve of statutory provisions which are to be administered by a provincial Department of Health in lieu of a Commis-
35 sion, but no measure of health insurance for a province shall be so approved, if, by its terms or in effect, it excludes from its benefits any person ordinarily resident in the province, or any specific area thereof.

(2) Where the statutory provisions respecting health Contributions to have priority in case of bankruptcy.
40 insurance provide for the payment of health insurance contributions to provincial authorities, such authorities shall, in the event of the bankruptcy of the person liable to pay or remit the contributions, have in respect of any unpaid contributions the same priority as is accorded wage-
45 earners with respect to wages under the *Bankruptcy Act*. R.S., c. 11.

Extent of
statutory
provisions
respecting
public
health.

5. The statutory provisions as respects general public health services shall include the establishment and maintenance of the services set forth in the Third Schedule to this Act, or substantially as therein set forth, or of such services as, having regard to all the circumstances, for the special conditions affecting the province as a whole, or any special areas therein, may be approved by the Governor in Council as a satisfactory practical measure of general public health for the province. 5

Approval by
Governor in
Council of
statutory
provisions.

6. The statutory provisions, other than those referred to in sections four and five hereof, shall be such as may be approved by the Governor in Council as a sound basis for attaining the objects which the grants are intended to secure, and shall provide such moneys for those objects as may from time to time be required. 10 15

Agreement
based on
report by
Minister.

7. (1) Every agreement made under section three of this Act shall be based on a report by the Minister to the effect that the conditions specified in this Act for the making of the agreement have been complied with.

Terms of
agreement.

(2) There shall be included in every such agreement, 20

Making
effective
provisions
of Act.

(a) such terms as may be necessary to make effective any provisions of this Act which would not otherwise be effective;

Provision
for records
necessary
to show
operations
and effect.
Statistics.

(b) provision for the maintenance by the province of such records and accounts as may be necessary to disclose in full the operations and effect of the agreement, and as far as may be practicable these provisions shall be uniform in all such agreements; and 25

(c) provision for the collection of such statistics as may be necessary, to be recorded on a uniform basis by arrangement between the provinces and the Minister of Trade and Commerce of the Dominion of Canada. 30

Dominion
Statistician
to compile
data.

(3) The Dominion Statistician shall compile, tabulate and publish the statistical data aforesaid for the Dominion as a whole, and may furnish monthly, quarterly or annual compilations to each province according to a stated plan under the aforesaid arrangement. 35

Duration of
agreement.

(4) Every such agreement shall continue in force only as long as the province continues to give full effect to the agreement and to the statutory provisions on which the agreement is founded, and the statutory provisions continue to be acceptable to the Governor in Council as a satisfactory basis for making an agreement hereunder within the meaning of the foregoing provisions of this Act, 40

Continued
acceptability
to Governor
in Council of
statutory
provisions.

or until after the expiration of ten years from the date upon which the Governor in Council gives notice to the Lieutenant Governor of the province of an intention to determine the agreement. 10 years' notice by Governor in Council.

- 5 **8.** (1) All grants in pursuance of any agreement made hereunder and all moneys payable under subsection four of section three hereof shall be payable out of any unappropriated moneys in the Consolidated Revenue Fund of Canada on the certificate of the Minister to the effect that Grants on certificate of Minister.
- 10 the terms of the agreement have been duly complied with and that the statutory provisions on which the agreement is based continue to be such as would justify the making of an agreement hereunder.
- 15 (2) If at any time the Minister reports to the Governor in Council that the conditions of any such agreement are not being complied with, or that proper effect is not being given to the statutory provisions, or that the statutory provisions can no longer be considered to be a satisfactory basis for the making of an agreement hereunder, the Governor in Council may, on concurrence with a recommendation of the Minister in that behalf, make such reduction, as may in the circumstances appear reasonable, in the subsequent payments of any grant concerning which the Minister reports as aforesaid, but any such reduction in a grant shall Reduction of grants in certain circumstances.
- 20 not be made effective until the expiry of such period, not exceeding one year, as the Governor in Council may by notice allow to the province for the rectification of the matters reported on by the Minister, and any such period may in like manner be extended on report and recommendation of the Minister with the concurrence of the Governor in Council.
- 25 (3) In notifying the province as aforesaid, a full statement of particulars of the matter so reported on by the Minister shall be furnished to the province. Statement to province of matters inducing reduction.
- 35 **9.** (1) The Minister may, at the request of a province and subject to such terms as may be agreed upon, assist such province in carrying into effect the terms of the agreement and of the statutory provisions on which the agreement is founded:—
- 40 (a) in case of an emergency affecting the health of the people; Circumstances in which assistance may be given.
- (b) for any special investigation or inquiry;
- (c) as respects any specific problems of administration;
- or
- 45 (d) for the purpose of enabling any province to bring into operation any agreement hereunder with such province.

How
assistance
may be
given.

- (2) The Minister may render assistance as aforesaid by
- (a) affording opportunities for consultation between professional and technical members of his staff and the members of the staff of the province concerned;
 - (b) placing technical and professional personnel at the disposal of the provincial authorities; 5
 - (c) making available to the provincial authorities drafts of regulations and forms and draft procedure for carrying into effect any agreement made under this Act;
 - (d) making available for the purposes aforesaid, and subject to any regulations or orders made under this Act, such financial assistance as Parliament may from time to time provide; and 10
 - (e) such other means as he may deem necessary or expedient for the execution of the purposes of this section. 15

Data in
Dominion
offices;
availability
to province.

10. For the purposes of enabling a province to bring into operation any scheme of health insurance for which an agreement has been made, the Governor in Council may order that there be made available to such province any data concerning persons residing therein which may have been obtained as the result of any registration. 20

Provincial
admini-
strative
reports;
copies for
Minister by
agreement.

11. In any agreement made hereunder it shall be provided

- (a) that unless the Minister otherwise directs in any case, a copy of every statistical or other report made by any local or regional authority to the provincial authorities and a copy of every like report made by the provincial authorities for use of the Lieutenant Governor in Council or of any department of government as respects the operations under any statutory provision by virtue of which an agreement has been made hereunder, shall be deposited with the Minister as soon as may be after the report is made; 25
- (b) that the said provincial authorities shall from time to time furnish to the Minister such additional statistical and other data as may in the opinion of the Minister be necessary 35
 - (i) to enable him to carry out the terms of this Act and of any agreement made thereunder, and 40
 - (ii) to set forth the extent and nature of the operations aforesaid as fully as the Minister may from time to time require;
- (c) that the provincial authorities shall at all times make available to the Minister, or to his representative, all records, documents, accounts and statistics relating to the operations aforesaid; and 45

Additional
information
from
province.

Records of
provincial
authority;
availability.

(d) that the Lieutenant Governor in Council shall appoint to the Health Insurance Commission two members to be nominated by the Governor General in Council.

Nominees
of G. G. in
Council.

5 **12.** (1) The Governor in Council may, on the recommendation of the Minister, appoint a person to investigate and report on all questions relating to the operations under any agreement made under this Act.

Investigation
and report
on provincial
operations.

10 (2) For the purpose of any such investigation the person so appointed shall have the powers of a Commissioner under the *Inquiries Act*.

Powers
of person
appointed for
investigation.
R.S., c. 99.

13. (1) Any person authorized by the Minister to act as an inspector may, for the purpose of the execution of this Act, and subject to the instructions of the Minister,

Powers
of duly
authorized
inspectors.

15 (a) inquire into any matters concerning which a report is required to be made under the last preceding section of this Act or concerning the operations therein referred to;

Inquiry into
matters
subject to
report and
concerning
operations.

20 (b) make such examination and inquiry as may be necessary for ascertaining whether proper effect is being given to the statutory provisions on which any agreement is based and to the terms of any such agreement, and whether the said statutory provisions continue to be a satisfactory basis for such an agree-
25 ment; and

Inquiry as to
compliance
with
statutory
provisions
and terms of
agreement
and as to
effectiveness
of statutory
provisions.

(c) exercise any of the powers of inspection provided for in section thirty-three of "A Draft for a Health Insurance Act" contained in the Second Schedule to this Act:

Powers of
inspection.

30 Provided that the provisions of this subsection shall not apply to the private office where any person carries out his professional undertakings pursuant to arrangements made with him under any statutory provision under which an agreement is made hereunder as respects health insurance,
35 nor to such person.

Proviso.

(2) Every inspector shall be furnished with a certificate of his appointment as such, and, on applying for admission to any premises or place for the purpose of carrying out his duties under this Act, shall, if so required, produce the said
40 certificate to the occupier of such premises or place.

Certificate of
appointment
of inspector;
production
of when
required.

(3) If any person wilfully delays or obstructs an inspector in the exercise of his duties, or fails to give such information or to produce such documents as are required to be produced or given, or conceals or prevents or attempts to conceal or
45 prevent any person from appearing before or being examined

Penalty
for wilful
obstruction
of inspector.

by an inspector, he shall be guilty of an offence under this Act and liable on summary conviction to a fine not exceeding twenty-five dollars.

Power of
Governor in
Council
to make
necessary
regulations.

14. The Governor in Council may make any orders or regulations necessary for giving effect to the purposes and intent of this Act, which orders and regulations shall have the force of law from the date of their publication in the *Canada Gazette*, and shall forthwith be published in the *Canada Gazette*. 5

Establish-
ment of
Health
Insurance
Division.

15. For the administration of this Act, there shall be established a Health Insurance Branch in the Department of Pensions and National Health directed by a doctor of medicine, regularly qualified, duly licensed in Canada, and preferably possessed of a Public Health diploma, who shall be known as the "Director of Health Insurance". 10 15

National
Council on
Health
Insurance.

16. (1) There shall be a National Advisory Council on Health Insurance consisting of the Director of Health Insurance who shall be chairman, the chief administrative officer of health insurance of any province which brings into operation a Health Insurance Act approved by the Governor in Council in accordance with the provisions of section four of this Act (appointed with the consent of the province concerned), and, in addition, such other persons representative of qualified persons, public health officers, medical practitioners, dental practitioners, pharmacists, hospitals, nurses, industrial workers, employers, agriculturists, rural women and urban women, respectively, as may be appointed by the Governor in Council, and representatives of such other groups as may be determined by Order of the Lieutenant Governor in Council of any province concerned: Provided that at least one of such persons shall be appointed in respect of each of the professions, classes and groups aforesaid, and that as far as possible there shall be equality of representatives of those qualified to provide and those qualified to receive health insurance benefits. 20 25 30 35

Proviso.

Term of
office of
members.

(2) The members appointed as aforesaid shall hold office for three years and may be re-appointed on the expiry of their term of office.

Meetings.

(3) The Council shall hold an annual meeting at Ottawa and shall meet at such other times and places as the Minister may direct. 40

Duties and
powers of
Council.

(4) The Council shall be charged with such duties as the Governor in Council may prescribe.

Reports to
Minister.

(5) All reports of the Council shall be made to the Minister in such form and under such conditions as he may require. 45

Travelling
and living
expenses to
members.

(6) Each member of the Council shall receive such travelling and living expenses in connection with the work of the Council as may be approved by the Governor in Council.

(7) The Minister may from time to time refer to the Council for consideration and advice such matters relating to the operation of this Act as the Minister thinks fit.

Reference of
matters by
Minister to
Council.

17. (1) In addition to the members of the Council appointed in accordance with the last preceding section of this Act, each of the professional and other groups enumerated in that section, and any other organization or group of persons having an interest in health insurance, shall be entitled to be represented at any meeting of the Council by not more than two persons to be known as delegates.

Attendance of
delegates at
meetings of
Council.

(2) Any organization or group of persons desiring to be represented by delegates at meetings of the Council may notify the Chairman to that effect and shall thereupon become entitled to be so represented.

Notice to
Chairman.

(3) Any such organization or group of persons shall be entitled to receive notice of meetings at the same time and in the same manner as notice is given to or in respect of members of the Council.

Notice of
meetings.

(4) A delegate shall be entitled to take part in the discussion of any question being considered by the Council at any meeting, subject to the consent of the Council on each request so to do, but shall not be entitled to vote on any question or otherwise take part in the proceedings of the Council.

Rights of
delegates.

(5) A delegate shall not be entitled to either remuneration or expenses in connection with the work of the Council.

No remunera-
tion.

18. The Minister shall lay before both Houses of Parliament, within the first thirty days of each session thereof, a return containing:—

Return by
Minister to
Parliament
each session.

(a) a full and clear statement of all transactions in pursuance of this Act, and of any agreements made thereunder, during the fiscal year preceding such session;

(b) copies of all orders and regulations made under this Act; and

(c) statements in summary form concerning the operations by the provinces under any agreements made hereunder, together with such additional information as the Minister may consider in the public interest.

FIRST SCHEDULE

(Section 3)

Designation of Grant	Objects of Grant	Special Conditions Governing Grant	Annual Amount of Grant
Health Insurance Grant	To provide health insurance benefits.	Approval by the Governor in Council of the statutory provisions respecting health insurance adopted by the province.	The amount specified in section three.
General Public Health Grant	To assist the province in establishing and maintaining general public health services.	Approval by the Governor in Council of the public health services conducted by the province.	An amount not to exceed the sum obtained by multiplying twenty-five cents by the total number of residents in the province.
Special Grants:			
(1) Tuberculosis Grant	To assist the province in providing free treatment for all persons suffering from tuberculosis.	The province within five years of the coming into force of this Act to provide free treatment, to the satisfaction of the Governor in Council, for all persons resident in the province, suffering from tuberculosis.	Not more than one-quarter of the total moneys, excluding capital expenditure, expended by the province during the previous fiscal year for the free treatment of persons resident in the province, suffering from tuberculosis; the total amount to be distributed among the provinces of Canada not to exceed \$2,000,000.00 and the amount of the grant to a province to be distributed: one-half on the basis of population and one-half on the basis of the average number of deaths from tuberculosis during the previous five years.
(2) Mental Disease Grant	To assist the province to provide free treatment for all persons suffering from mental illness and for mental defectives.	The province within five years of the coming into force of this Act to provide free treatment, to the satisfaction of the Governor in Council, for all persons resident in the province, suffering from mental illness including mental defectives.	Not more than one-seventh of the moneys, excluding capital expenditure, expended by the province during the previous fiscal year for the free treatment of residents of the province suffering from mental illness and for mental defectives; the total amount to be distributed among the provinces of Canada not to exceed \$2,500,000.00; the amount of the grant to a province to be distributed on the basis of population.

FIRST SCHEDULE—*Concluded*

Designation of Grant	Objects of Grant	Special Conditions Governing Grant	Annual Amount of Grant
(3) Venereal Disease Grant	To assist the province in the prevention and free treatment of the venereal diseases.	The province within five years of the coming into force of this Act to establish measures for the prevention of the spread of venereal diseases and to provide free treatment, to the satisfaction of the Governor in Council, for all persons suffering from the venereal diseases.	Not in excess or \$1,000,000.00 for a period of ten years; one-half to be divided on the basis of population and one-half according to the number of new cases of venereal disease reported in the province in the previous calendar year; the amount of the grant not to exceed one-half the amount expended by the province.
(4) Professional Training Grant	To assist the province to provide for the training in public health of physicians, engineers, nurses and sanitary inspectors.	The province to satisfy the Governor in Council of the need for the grant and of its effective employment.	Not to exceed \$100,000.00 to be allocated to the provinces by the Governor in Council.
(5) Public Health Research Grant	To assist the province in carrying on public health research.	The province to satisfy the Governor in Council of the need for the grant and of its effective employment.	Not to exceed \$50,000.00 to be allocated to the provinces by the Governor in Council.
(6) Crippled Children Grant	To assist the province in the prevention and control of crippling conditions in children.	Approval by the Governor in Council of the plan adopted by the province.	Not to exceed \$250,000.00 to be allocated to the provinces by the Governor in Council.

SECOND SCHEDULE

(Section 4)

A DRAFT FOR A HEALTH INSURANCE ACT

HIS Majesty, by and with the advice and consent of the
Legislative Assembly, enacts as follows:

SHORT TITLE

Short title. **1.** This Act may be cited as *The Ontario* (or as the case may be) *Health Insurance Act, 194* .

INTERPRETATION

Definitions. **2.** (1) In this Act and in any regulations, agreement or order made thereunder, unless the context otherwise requires,

"adult". (a) "adult" means any person who has attained his sixteenth birthday and whose normal place of residence is in the province;

"Commission." (b) "Commission" means the authority set up by the Province, for the purpose of administration of this Act;

"juvenile". (c) "juvenile" means any person who has not attained his sixteenth birthday and whose normal place of residence is in the province;

"Minister". (d) "Minister" means the Minister of Health;

"pre-scribed". (e) "prescribed" means prescribed by regulation of the Commission;

"regulations." (f) "regulation" means a regulation made pursuant to this Act.

Meaning of certain expressions. (2) In this Act and in any regulation, agreement or order made thereunder, unless the context otherwise requires, each of the following expressions shall have the meaning assigned thereto in the section of this Act cited in this subsection:

(a) "contributor",	section 5;
(b) "health insurance books",	section 7;
(c) "health insurance cards",	section 7;
(d) "Health Insurance Fund",	section 9;
(e) "health insurance stamps",	section 7;
(f) "income",	section 6;
(g) "medical practitioners",	section 11;
(h) "qualified person",	section 3.

PERSONS COVERED BY THIS ACT

3. (1) Every adult in whose case the requirements of the Act are complied with by him or on his behalf and every juvenile of whom he has for the time being the care and control shall be qualified to receive the benefits of health insurance conferred by this Act. All adults and juveniles.

(2) A person who is qualified to receive the benefits of health insurance conferred by this Act may be referred to as a "qualified person". "qualified person".

(3) The Commission shall prescribe the terms and conditions under which a qualified person may obtain his health insurance benefit while temporarily outside the Province. Persons outside the province.

REGISTRATION

4. (1) Every adult shall, on or before a prescribed date, file with the Commission a return in prescribed form and manner and containing such information as may be prescribed, for the purpose of enabling the Commission to establish and maintain a register of qualified persons and for other purposes of this Act. Adults' returns.

(2) Every person who files a return shall answer promptly any inquiries of the Commission concerning any entry in the return or concerning any omissions therefrom, and the Commission shall make such other inquiries as may appear necessary to ascertain the correctness of the return and of any information obtained as a result of any such inquiry. Inquiries to be answered.

(3) The Commission shall not be bound by any entry in any such return nor by information obtained as a result of any inquiry as aforesaid. Commission not bound.

CONTRIBUTORS

5. (1) Except as provided in this section and section six of this Act, every adult shall pay to the Health Insurance Fund a contribution of dollars in each year in such manner and at such time and place as may be prescribed. Who shall pay. 參閱

(2) An adult who is wholly dependent on another adult for support shall not be required to pay the contribution mentioned in subsection one of this section, but the person on whom he is dependent shall, in addition to the contribution required to be paid by him, pay to the Health Insurance Fund a contribution of the amount specified in subsection (1) hereof on behalf of the dependent adult in each year he is so dependent. Contributions for dependants.

(3) Where an adult is partially dependent on another adult for support, or is wholly dependent for a period less than a year, the Commission may prescribe the amount of the contribution to be paid by each of such persons. Adult partially dependent or for less than a year.

Who are
dependants.

(4) The Commission may by regulation prescribe the persons or class of persons who shall for the purpose of this section be deemed to be dependants.

"contri-
butors".

(5) Persons who are required by this section to pay a contribution may be referred to as "contributors".

ADJUSTMENT OF CONTRIBUTIONS

Contribu-
tions may be
reduced.

6. (1) Where the income of a contributor is less than an amount prescribed, the contribution otherwise payable by him under section five of this Act may, upon application, be reduced by such amount as the Commission may determine in accordance with the regulations.

Income,
how
determined.

(2) The Commission may make regulations prescribing the manner in which the income of any person shall be determined for the purposes of subsection one of this section.

Sums to be
paid into the
H.I.F.

(3) The Provincial Treasurer shall, out of any unappropriated moneys forming part of the Consolidated Revenue Fund, pay into the Health Insurance Fund sums equal to the amounts by which contributions have been reduced under subsection one of this section.

Appeal.

(4) An appeal may be made by any person against the findings of the Commission in respect of the determination of his income for the purposes of this section.

Regulations
respecting
appeals.

(5) The Commission may make regulations prescribing the time and manner of making appeals, the constitution of the authority to hear and decide appeals and any decision made by such authority shall be final and conclusive and not subject to review.

METHODS OF PAYMENT

Payment
and
collection of
contributions.

7. (1) Subject to the provisions of this Act, the Commission may make regulations providing for any matters relating to the payment and collection of contributions payable under section five of this Act, and in particular for

(a) specifying the manner, times, and conditions in, at and under which payments are to be made;

(b) requiring employers to collect from their employees the contributions payable by the employees under section five of this Act, by deductions from salary or wages or otherwise and to remit the amounts collected to the Commission;

(c) the entry in or upon health insurance books or cards of particulars of contributions paid in respect of the persons to whom the health insurance books or cards relate;

(d) the issue, sale, custody, production, and surrender of health insurance books or cards and the replacement of health insurance books or cards which have been lost, destroyed, or defaced; and

(e) the offering of reward for the return of a health insurance book or card which has been lost and for the recovery from the person responsible for the custody of the book or card at the time of its loss of any reward paid for the return thereof.

(2) The Commission may by regulation provide for the payment of contributions, and of contributions in arrears, by means of stamps (in this Act referred to as "health insurance stamps") affixed to or impressed upon books or cards (in this Act respectively referred to as "health insurance books" and "health insurance cards") or otherwise, and such stamps or the devices for impressing the same, or other methods of payment, shall be prepared and issued in such manner as may be provided by the regulations.

Methods of payment.

(3) The Commission may by regulations provide for the issue, custody, production, cancellation and surrender of stamps, and may enter into an agreement with the Postmaster General of Canada, or such other persons as may be prescribed, for the sale of stamps.

Stamps, issue, cancellation, etc.

REFUND OF CONTRIBUTIONS

8. Where a contributor pays money to the Health Insurance Fund under section five of this Act in excess of the contributions he is by that section required to pay, a refund of such excess amount may be made to him, under such terms and conditions as the Commission may prescribe, if such excess amount is not less than fifty cents.

Refund of excess amount paid.

HEALTH INSURANCE FUND

9. (1) There shall be a special account in the Consolidated Revenue Fund of the Province called the Health Insurance Fund (in this Act referred to as "The Fund"), to which the Provincial Treasurer shall from time to time credit

Health Insurance Fund for receipt of moneys.

(a) all contributions paid under this Act;

(b) penalties payable to the Fund;

(c) all grants made to the Province by the Government of Canada for the purposes of this Act and all payments made under subsection four of section three of the *National Health Act*, chapter of the statutes of Canada, 1944, to the Province by the Government of Canada based upon the health insurance contributions payable under Part of the *Income War Tax Act*, chapter ninety-seven of the Revised Statutes of Canada, 1927;

(d) any sums payable to the Fund out of the revenues of the Province under the terms of this Act or otherwise, together with any other sums received on behalf of the Fund; and

(e) interest earnings on any investments of the Fund.

Payments
out of
Fund by
Provincial
Treasurer.

(2) The Provincial Treasurer may, subject to the provisions of this Act and to any regulations made thereunder, on requisition of the Commission or its authorized officers, pay out of the Fund any sums which may be required to pay the costs of the benefits of health insurance conferred by this Act.

Provision of
investment
committee
by regulation.

(3) Regulations may be made hereunder for the purpose of

(a) authorizing the appointment of a committee, with powers defined by the regulations, to invest from time to time any part of the Fund not currently required for the purposes of this Act and to sell or exchange investments so made for other like investments; and

(b) making effective the intentions of this section.

BENEFITS

Benefits:
preventive,
diagnostic
and curative.

10. (1) Subject to the provisions of this Act and to any regulations made thereunder, the benefits conferred by this Act on qualified persons shall be such as to provide for the prevention of disease and for the application of all necessary diagnostic and curative procedures and treatment.

Kinds of
benefits.

(2) The benefits referred to in the last preceding subsection shall be administered under the following heads, namely:

(a) Medical, surgical and obstetrical benefits;

(b) Dental benefit;

(c) Pharmaceutical benefit;

(d) Hospital benefit;

(e) Nursing benefit.

Special
technical and
ancillary
services
to make
benefits
effective.

(3) The benefits referred to in the last preceding subsection shall include such special and technical procedures and ancillary services as may be prescribed and as may, in accordance with regulations made hereunder, be deemed necessary to make effective the said benefits in the case of any qualified person.

Urgency of
need basis of
entitlement in
emergencies
and special
circum-
stances.

(4) Notwithstanding anything in this Act contained, if, on account of insufficient professional personnel, facilities or equipment, it is found not to be practicable, in an emergency or in any other circumstances, to provide any of the said benefits for all persons entitled thereto, the said benefits shall, as far as may be practicable and in accordance with regulations made hereunder, be made available to such of the persons aforesaid as may at the time be most urgently in need thereof.

MEDICAL, SURGICAL AND OBSTETRICAL BENEFITS

11. (1) For the purpose of administering medical, surgical, and obstetrical benefits, the Commission shall, in accordance with regulations made hereunder, make arrangements therefor with practitioners in medicine, surgery, and obstetrics who are regularly qualified, duly licensed and in good standing in the province (in this Act referred to as "medical practitioners"), including specialists and consultants in medical, surgical, and obstetrical diagnosis and treatment.

Arrangements with practitioners for carrying out plan.

(2) The regulations and arrangements aforesaid shall be such as to secure that qualified persons shall, subject to the provisions of this Act, receive from medical practitioners with whom arrangements are so made all such adequate measures for the prevention of disease, and all such proper, necessary and adequate medical, surgical, and obstetrical treatment, attendance, and advice as may be prescribed, and the said regulations and arrangements shall, subject to such terms and limitations as may be included therein, be such as to secure

Professional services to provide preventive and various kinds of curative measures.

- (a) the preparation and publication of lists of medical practitioners who have agreed to attend, treat and advise qualified persons, and the class or classes of service each such practitioner is qualified and prepared to provide;
- (b) the right on the part of any medical practitioner as aforesaid, who is desirous of being included in any such list, of being so included on making application to that effect in the prescribed manner;
- (c) the right on the part of any qualified person, not being a juvenile, of selecting, at such times as may be prescribed, from the appropriate list the medical practitioner by whom he wishes himself to be attended, treated, and advised, and of selecting in like manner the medical practitioner by whom he wishes any qualified juvenile, of whom he has for the time being the care and control, to be attended, treated, and advised, subject in each case to the consent of the medical practitioner so selected;
- (d) the right on the part of any qualified person to the services of specialists and consultants, ordinarily after consultation with and on the recommendation of the medical adviser that person may have selected as aforesaid, and the right on the part of that person to select the specialist or consultant, subject to any regulations made in that behalf;
- (e) the distribution among the several medical practitioners whose names are on the lists, so far as practicable under arrangements made by them, of the qualified

Lists of practitioners with particulars of class of service available in each case.

Right of practitioner to be included in list.

Right of person to select practitioner.

Right of person to services of specialists and consultants.

Distribution among practitioners of persons who fail to select.

Medical practitioners for prevention of diseases and conservation of health.

No remuneration to practitioner who exceeds professional competence.

Remuneration of practitioners.

Necessity for keeping clinical records. Divulgence of clinical data.

Arrangements with approved clinics.

Regulations for establishing classes of professional services, etc.

persons who after due notice have failed to make any selection or who have been refused by the medical practitioner whom they have selected;

(f) the services of medical practitioners in the prevention of disease and in the conservation of health, as provided in the arrangements aforesaid;

(g) that, except in case of an emergency, no medical practitioner shall be entitled to remuneration from the Fund for any service rendered to any qualified person in the performance of which the medical practitioner has exceeded his professional competence as shown by the lists aforesaid;

(h) that the method or methods of remuneration of medical practitioners and the rate thereof, whether by capitation, by fees, or by salary, or by any combination thereof, or otherwise, shall be such as may be provided for in the arrangements aforesaid with medical practitioners and shall be subject to revision from time to time as may be provided for in the regulations;

(i) the keeping of adequate and satisfactory clinical records by medical practitioners as prescribed; and

(j) that the legal responsibilities of medical practitioners concerning the divulgence of clinical data as respects any qualified person shall be defined.

(3) Arrangements with medical practitioners made under the provisions of this section may include arrangements with approved clinics, or groups of medical practitioners practising in co-operation, whereby qualified persons may select any such clinic or group of practitioners in lieu of selecting a medical practitioner as provided in this section.

(4) Regulations shall prescribe

(a) the rules and procedure to be followed in determining the class or classes of professional services, other than general practitioner services, which is or are within the competence of each medical practitioner who is desirous of being included in any list as aforesaid; and

(b) the classes of services which shall be deemed to be general practitioner services, either for the province generally or for particular regions or areas thereof, with any modifications therein which may be necessary to meet special circumstances or special cases, or to meet the case of any general practitioners who do not desire to supply all of the said services to qualified persons.

DENTAL BENEFIT

Arrangements with dentists for carrying out plan.

12. (1) For the purpose of administering dental benefit, the Commission shall, in accordance with regulations made hereunder, make arrangements with registered dental practitioners, including specialists in dentistry, for the

purpose of carrying out the programme of dental services which may be established in accordance with the said regulations.

(2) The terms of the programme aforesaid shall be such as to secure, subject to such terms and limitations as may be included therein, Necessary terms of program.

(a) that the services thereunder shall be in accordance with recognized professional standards for sound dentistry; Recognized standards of dentistry.

(b) that the classes of persons entitled to benefit under the programme shall not be greater than can be served from time to time in accordance with the standards aforesaid by the dental practitioners with whom arrangements are made; and Extent of program limited by available professional personnel.

(c) that dental services in accordance with the standards aforesaid be extended to all persons under health insurance as soon as may be practicable. Eventual extension of program.

(3) Without limiting the generality of the powers conferred by this section, the programme may in the first instance be limited to persons not over a prescribed age, subject to advance in that age from time to time, having regard to the number of dental practitioners available for rendering the required services. At first limited to persons not over prescribed age.

(4) For the effective and economic administration of the program, persons entitled to benefit thereunder may, in accordance with regulations made in that behalf, be required to attend at prescribed times at the office of the dental practitioner selected by those persons. Attendance for services; penalty for failure.

(5) The arrangements made with dental practitioners as aforesaid shall be such as to secure, subject to such terms and limitations as may be included in regulations made in that behalf, Arrangements.

(a) the preparation and publication of lists of dental practitioners who have agreed to treat and advise qualified persons, and the class or classes of service each such dental practitioner is qualified and prepared to provide; Lists of practitioners.

(b) the right on the part of any registered dental practitioner who is desirous of being included in any such list as aforesaid of being so included on making application to that effect in the prescribed manner; Right of practitioner to be included in list.

(c) the right on the part of any qualified person, not being a juvenile, of selecting at such times as may be prescribed, from the appropriate list the dental practitioner by whom he wishes himself to be treated and advised, and of selecting in like manner the practitioner by whom he wishes any qualified juvenile, of whom he has for the time being the care and control, to be treated and advised, subject in each case to the consent of the dental practitioner so selected: Right of person to select practitioner.

Distribution among practitioners of persons who fail to select or have been refused by selected practitioner.

Right of person to services of specialist and consultant.

No remuneration to practitioner who exceeds professional competence.

Remuneration of practitioners.

Necessity for keeping clinical records.

Regulations for establishing classes of professional services, etc.

(d) the distribution among the several dental practitioners whose names are on the lists, so far as practicable under arrangements made by them, of the persons entitled to services under the programme who after due notice have failed to make any selection, or who have been refused by the dental practitioner whom they have selected;

(e) the right on the part of any qualified person to the services of specialists and consultants in dentistry as may be recommended from time to time by the dental practitioner whom that person may have selected as aforesaid, and the right of that person to select the specialist or consultant, subject to any regulations made in that behalf;

(f) that, except in case of emergency, no dental practitioner shall be entitled to remuneration from the Fund for any service rendered to a qualified person in the performance of which he has exceeded his professional competence as shown by the list aforesaid;

(g) that the method or methods of remuneration of dental practitioners and the rate thereof, whether by capitation, by fees or by salary, or any combination thereof, or otherwise, shall be such as may be provided for in the regulations and shall be subject to revision from time to time as may be provided for in the regulations; and

(h) the keeping of clinical records by dental practitioners as prescribed.

(6) Regulations shall prescribe the rules and procedure to be followed in determining the class or classes of professional services, other than general dental services, which is or are within the competence of each dental practitioner who is desirous of being included in any list as aforesaid.

PHARMACEUTICAL BENEFIT

Arrangements for supplying drugs.

13. (1) For the purpose of administering pharmaceutical benefit, the Commission shall, in accordance with regulations made hereunder, make arrangements for the supply of proper and sufficient drugs, medicines, materials, and appliances to qualified persons, and the regulations and arrangements aforesaid shall be such as to enable qualified persons to obtain such drugs, medicines, materials and appliances, if ordered by the practitioner by whom the qualified persons are attended, from any persons with whom arrangements have been made, and shall be such as to secure, subject to such terms and limitations as may be included therein,

- (a) that, except to the extent to which medical practitioners and dental practitioners may, in accordance with the arrangements made with them, be required to supply such drugs, medicines, materials and appliances for immediate use or in emergencies or in remote areas, arrangements shall be made only with retail pharmacists (including chemists and druggists) registered in the province; Except as to doctors and dentists, arrangements to be made only with registered pharmacists.
 - (b) that lists of pharmacists with whom arrangements have been made as aforesaid shall be prepared and published; Lists of pharmacists.
 - (c) that any pharmacist registered in the province desirous of being included in any such list as aforesaid shall be so included on making application therefor in the prescribed manner; Right of pharmacist to be included in list.
 - (d) that the person for whose benefit an order for any drug, medicine, material, or appliance is given shall have the right to select the pharmacist by whom the order shall be filled; Right of person to select pharmacist.
 - (e) that except as may otherwise be prescribed, a pharmacist shall not supply drugs, medicines, materials, or appliances if the order therefor is written in such manner as to necessitate reference on the part of the pharmacist to a previous order; and Written order for drugs and reference to previous order.
 - (f) that orders for drugs, medicines, materials, and appliances supplied shall be priced by a central board, bureau or committee for the whole province in accordance with a tariff agreed upon between the Commission and associations representative of pharmacists, and in accordance with regulations made in that behalf. Prices of drugs according to tariff.
- (2) Regulations may be made hereunder from time to time authorizing a provincial drug formulary for the purpose of this Act. Drug formulary.

HOSPITAL BENEFIT

- 14.** (1) For the purpose of administering hospital benefit, the Commission shall, in accordance with regulations made hereunder, make arrangements for all necessary hospital services for qualified persons in hospitals (including out-patient departments of hospitals and convalescent homes) other than hospital services for pulmonary tuberculosis or mental illnesses (except as may otherwise be prescribed), and the regulations aforesaid shall be such as to secure, subject to such terms and limitations as may be included therein, Arrangements for hospital services.
- (a) the preparation, and publication as may be prescribed, of lists of hospitals with which arrangements as aforesaid have been made, showing in the said lists the classes List of hospitals with services available.

of hospital services each such hospital is capable of providing and authorized to provide under the said arrangements;

Classes of hospitals which may be used.

Hospital services on order of medical practitioner. Right of person to select hospital.

Right of hospital respecting medical practitioners treating patients.

Compensation of hospitals.

General ward service only except as may be provided by regulations in certain cases.

Private and semi-private ward service as extra payable by qualified person.

Persons available for clinical observation.

- (b) that, except as may otherwise be prescribed, arrangements shall be made only with (i) hospitals recognized by the province as "non-profit voluntary hospitals", (ii) municipal hospitals, (iii) provincial government hospitals and (iv) Dominion Government hospitals, and that the said hospitals shall, subject to the classification thereof as provided in paragraph (a) hereof, be on an equal footing under the said arrangements;
- (c) that a qualified person shall be entitled to hospital services only when ordered by the medical practitioner by whom the qualified person is attended;
- (d) that any person for whom hospital services are ordered as aforesaid shall have the right of selection of the hospital from among the hospitals capable of providing the services required;
- (e) that the governing body of each hospital shall have the right to determine the medical practitioners who shall have the right of treating patients therein;
- (f) that the compensation of hospitals shall be
 - (i) a basic rate for general care together with provision for diagnostic and therapeutic procedures, not provided under general care, at such tariff as may be prescribed, or
 - (ii) an inclusive rate for general care as aforesaid including such diagnostic and therapeutic procedures as may be prescribed, together with provision for other special diagnostic and therapeutic procedures at such tariff as may be prescribed, or
 - (iii) on such other basis as may be prescribed.
- (g) that in any case the arrangements aforesaid shall provide for general ward service as may be prescribed and that single-room service shall not be available as part of the hospital benefit unless in any particular case single-room ward service is determined, in accordance with the regulations made in that behalf, to be essential to the welfare of the patient;
- (h) that any qualified person in receipt of hospital services under arrangements as referred to in paragraphs (f) and (g) of this subsection shall have the right to semi-private or private ward service, if available, on payment by that person to the hospital of the difference in the charges therefor;
- (i) that any qualified person in receipt of hospital services as aforesaid shall be available for clinical observation for the instruction of students in medicine and nursing pursuant to regulations and arrangements made in that behalf;

- (j) that adequate and satisfactory records shall be kept by the hospital; and
- (k) that the legal responsibilities of the hospital and of its personnel concerning the divulgence of clinical data as respects any qualified person who has received hospital services as aforesaid shall be defined.
- (2) In making arrangements with hospitals in accordance with the provisions of paragraph (f) of subsection one of this section, basic rates for general care may, in manner prescribed, be determined for each hospital having regard for local costs and the facilities and services afforded by the hospital.
- (3) In the case of hospitals having what is known as "closed wards", whether for teaching purposes or otherwise, the medical staff in such hospitals shall receive such remuneration as may be prescribed for attendance, treatment, and advice in respect of qualified persons admitted to such wards.
- (4) Regulations may prescribe the rules and procedure to be followed in determining the classes of hospital services each hospital is capable of providing and authorized to provide and for determining what shall constitute general care in any case, or the regulations may constitute an authority or name an authority for determining the matters aforesaid or any of them.

Hospital records.

Defining of responsibility of hospital regarding divulgence of clinical data.

How hospital rates determined.

Remuneration of staff in "closed wards."

Regulations for establishing classes of services respecting hospitals.

NURSING BENEFIT

- 15.** (1) For the purpose of administering nursing benefit, the Commission shall, in accordance with regulations made hereunder, make arrangements for providing necessary nursing services for qualified persons and for the effective and economic administration of those services.
- (2) The regulations aforesaid shall be such as to secure, subject to such terms and limitations as may be included therein,
- (a) that the arrangements aforesaid shall be made through organizations which are representative of registered nurses, and may provide that, in special circumstances or for limited or special duties or purposes, nursing services may be supplied by persons with such training and experience in nursing as may be prescribed although falling short of the training and experience necessary for registration as a nurse, and that the names of all such persons shall be entered in lists as may be prescribed showing the classes of duties or services which may be provided by them as aforesaid, and such lists shall be available as prescribed for the purposes of this Act;

Arrangements for nursing benefit.

Regulations.

Registered nurses.

Nursing services by other persons; lists of such persons.

Nursing services only when ordered by practitioner. Use of local organizations and regard for special attributes of nurses on being assigned.

Right of selecting nurse.

Conditions relating to services of nurses subject to revision.

Maintenance of standards.

- (b) that nursing services shall be available only when ordered by the practitioner by whom the qualified person is attended;
- (c) that, as far as may be practicable, nursing service in each area shall be provided through the local organizations which are representative of registered nurses, and that regard shall be had for the general qualifications, special training and experience in assigning persons to render nursing services;
- (d) that any qualified person, not being a juvenile, for whom nursing services are ordered shall have the right of selecting, from the appropriate list, the nurse by whom he wishes himself to be attended and of selecting in like manner the nurse by whom he wishes any qualified juvenile, of whom he has for the time being the care and control, to be attended, subject in each case to the consent of the nurse so selected and the medical practitioner in attendance;
- (e) that the conditions of service, the hours of work and the methods and rate of remuneration of persons who may be employed to render nursing services for the purposes of this Act shall be subject to reconsideration and revision from time to time; and
- (f) that the accepted standards of nursing training and nursing services which may be from time to time recognized as satisfactory shall be maintained.

MEMBERS OF PROFESSIONS ON MILITARY SERVICE

Provision for re-establishment of members of professions serving in His Majesty's Forces.

16. Notwithstanding anything in this Act, the regulations made under the provisions of sections eleven, twelve, thirteen, fourteen and fifteen thereof, shall be such as will secure the establishment or the re-establishment, as the case may be, in civilian professional life of the members of the several professions referred to in the said sections who may be discharged from His Majesty's Naval, Military or Air Forces (including Women's Divisions thereof), such establishment or re-establishment to be to the same extent and on the same footing, as nearly as may be, as those persons would be established or re-established had they been discharged from the Forces before the coming into operation of this Act.

SPECIAL PROVISIONS AS TO BENEFITS

After benefits available; survey of conditions

17. (1) (a) As soon as may be after benefits become available to qualified persons under this Act, and thereafter whenever it may seem desirable so to do, or at

the direction of the Commission, the committee empowered thereunto in each region shall, after making a complete survey of the conditions throughout the region, or such survey as may be directed by the Commission concerning the administration of the benefits of this Act, the availability of professional personnel, and the facilities for administering the said benefits, prepare a report for the Commission describing the conditions prevailing in particular areas throughout the region as respects the provisions of this Act, and where deemed necessary, containing therein a scheme or schemes for improving in practical ways the administration of the benefits aforesaid and for making those benefits as readily available as may reasonably be practicable to persons living in all parts of the region, and the report shall show in order of urgency, the several recommendations and the estimated cost thereof:

in region;
contents of
report to
Commission.

(b) With a view to expedition the committee may in a preliminary report make recommendations for forthwith providing adequate general practitioner services and nursing services in any localities not being adequately served or not likely to be adequately served in respect of those services:

Preliminary
report by
committee.

(c) The Commission may direct that such a survey and report be made concerning any region before benefits become available under this Act.

Commission
may direct
survey and
report before
benefits
available.

(2) The Commission shall consider any reports so made and, after making such additional inquiries and investigations as may seem necessary or desirable, shall, subject to the provisions of the next following subsection, put into effect such a programme as may for the time being be deemed practicable and advisable for making available the benefits of this Act to qualified persons throughout the province.

Duty of
Commission
on receipt
of reports.

(3) If, as respects any particular area, in the opinion of the Commission, it is not reasonably practicable to administer satisfactorily any one or more than one of the benefits of this Act under the general arrangements made for administration thereof, the Commission may, by regulation made hereunder,

Power of
Commission
to vary or
modify
arrangements
respecting
particular
area or
substitute
scheme.

(a) make other arrangements for the administration of benefits in that area; or

(b) put into operation such modification of the scheme of benefits of the Act as may be practicable for that area; or

(c) put into operation such alternative scheme of health insurance benefits or services and arrangements for administration thereof as may be deemed appropriate and in the best interests of persons in the area.

Power to recover cost of treatment under this Act as respects persons entitled to similar benefits under Workmen's Compensation Act or otherwise.

18. (1) If, in respect of any injury, sickness or disease, any person has received any benefits under the provisions of this Act and

- (a) in respect of that injury, sickness or disease, has recovered, or is entitled to recover, under the Workmen's Compensation Act or under any other Act or otherwise, any compensation or damages on account of any treatment or attendance, or on account of the supply of any medicine, drugs, materials or appliances, being benefits or any of them received by him as aforesaid; or
(b) is or was entitled to receive under any Act as mentioned under paragraph (a) hereof, or otherwise, the benefits, or any part thereof, which he in fact received as aforesaid under this Act,

then, there shall be payable to the Fund by that person, if he has recovered compensation or damages as aforesaid, or by the authority or person liable to pay any such unrecovered compensation or damages or who is or was liable to provide the services, materials and appliances mentioned in paragraph (a) of this subsection, an amount up to the cost of the benefits received by that person as aforesaid under this Act but not exceeding the amount of the compensation or damages aforesaid or the cost of the benefits mentioned in paragraph (b) of this subsection received by that person.

Method of determining costs when no direct payment from Fund.

(2) If the benefits, or any of them, received by any such person under this Act as aforesaid did not involve a direct payment from the Fund, the cost thereof shall, for the purposes of this section, be determined having regard for the services rendered and in accordance with regulations made hereunder.

Debt due to Crown.

(3) Any amount due to the Fund under the provisions of this section shall be recoverable as a debt due to the Crown from the person or authority liable to pay the same as above provided.

ADMINISTRATION BY COMMISSION

Establishment of Health Insurance Commission.

19. (1) This Act shall be administered by a Commission to be called "The Health Insurance Commission" (in this Act referred to as "the Commission"), which shall consist of a Chairman and of such number of other commissioners as may from time to time be determined by Order of the Lieutenant-Governor in Council.

Chairman, qualifications of.

(2) The Chairman of the Commission shall be a doctor of medicine, regularly qualified, duly licensed and in good standing in the province, and having practised medicine for at least ten years, and shall be appointed by the Lieutenant-Governor in Council.

(3) The Deputy Minister of Health or the Provincial Health Officer shall, *ex officio*, be a member of the Commission.

Deputy Minister of Health or Provincial Health Officer a member.

(4) The other commissioners shall be appointed by the Lieutenant-Governor in Council after consultation with organizations representative of qualified persons, medical practitioners, dental practitioners, pharmacists, hospitals, nurses, industrial workers, employers, agriculturalists, rural women, urban women, and of such other groups or classes as may be determined by order of the Lieutenant-Governor in Council: Provided, however, that at least one of such commissioners shall be appointed in respect of each of the professions, of the provincial hospital associations, of the provincial nurses' associations, and of each of the remaining groups or classes aforesaid.

Other members, how determined for appointment.

Proviso.

(5) In default of organizations representative of qualified persons, the Lieutenant-Governor in Council may appoint a commissioner or commissioners, chosen in such manner as the Lieutenant-Governor in Council may by order determine.

Appointments where no organizations representative of qualified persons.

(6) The Chairman of the Commission shall hold office for such period as may be determined by the Lieutenant-Governor in Council but not exceeding ten years, and each of the other commissioners appointed by the Lieutenant-Governor in Council shall hold office for a period of two, four, or six years, as may be determined in each case in the order appointing the commissioner, but the term of office of the several commissioners first appointed hereunder shall be so determined that, as nearly as may be, an equal number of them shall complete their term of office at the end of each of the periods aforesaid, and thereafter appointments to the Commission, other than to the office of Chairman, shall be for a term of six years: Provided, however, that any person appointed to fill a vacancy in the Commission caused by death, resignation, or any other circumstance, shall hold office only until the date upon which the person in whose place he is appointed would regularly have completed his term of office.

Tenure of office of chairman and other commissioners.

Proviso.

(7) The office of any commissioner appointed hereunder shall become vacant for cause, or for permanent incapacity, or upon his attaining the age of seventy years.

Vacancy of office for cause, incapacity, or age.

(8) A commissioner upon expiration of his term of office, if under seventy years of age, shall be eligible for re-appointment.

Eligibility for re-appointment of commissioner.

Chairman,
duties as
chief admin-
istrative
officer of
supervision
and direction.

20. (1) The Chairman of the Commission shall be the chief administrative officer of the Commission and shall, in accordance with the provisions of this Act, of the regulations made hereunder, and of the directions laid down from time to time by the Commission, have supervision over, and direction of, the work of the Commission and of the officers appointed for the purpose of carrying out the work of the Commission.

Salary of
Chairman;
full-time
employment.

(2) The Chairman shall receive such salary as the Lieutenant-Governor in Council shall prescribe, and he shall devote his whole time to the work of the Commission.

Remunera-
tion and
travelling
expenses of
commis-
sioners.

21. No member of the Commission, with the exception of the Chairman, shall receive any salary but each shall receive such remuneration and travelling expenses in connection with the work of the Commission as may be approved by the Lieutenant-Governor in Council.

Meetings of
Commission;
times and
places.

22. (1) The Commission shall meet at least twice each year in such places and on such days as may be fixed by the Commission, and may also meet at such other times as the Commission may deem necessary.

Regulations
establishing
procedure
and quorum
at meetings.

(2) Regulations made hereunder shall establish
(a) the procedure to be followed in calling meetings, and at meetings, of the Commission; and
(b) the number of commissioners who shall form a quorum at any meeting.

By-laws.

(3) Subject to the terms of the said regulations, the Commission may make by-laws for the conduct of the business of the Commission, and may provide for giving assent or dissent in writing by mail to any matters submitted in writing by mail to the commissioners.

Commission
a corporation.

23. (1) The Commission shall be a body corporate having capacity to contract and to sue and to be sued in the name of the Commission.

Power to
acquire,
hold and
dispose of
property.

(2) The Commission shall have power, for the purposes of this Act, to acquire, hold and dispose of personal property, and, with the approval of the Lieutenant-Governor in Council, real property.

Head Office.

(3) The head office of the Commission shall be in the city of.....

Employees of
Commission,
appointment
and employ-
ment.

24. (1) Such officers, inspectors, clerks and other employees as are necessary for the proper conduct of the business of the Commission, whether at the Head Office of the

Commission or elsewhere, shall be appointed and employed in manner authorized by the law of the province relating to the public service.

(2) In addition to compliance with all other requirements for the purpose of securing the appointment of fit and proper persons as officers, clerks and employees, any person appointed to any executive, administrative or other position requiring professional training and experience in medicine, in dentistry, in pharmacy, in hospital work, or in nursing, shall be chosen after consultation with organizations representative, respectively, of medical practitioners, of dentists, of pharmacists, of hospitals or of registered nurses, as may be appropriate for the purpose of determining his fitness to discharge the duties and responsibilities of the position.

Appointment of skilled and professional personnel.

25. Except as otherwise provided in this Act the costs of administration of this Act, including the remuneration of the Chairman, officers, clerks and employees, shall be paid out of moneys provided by the Legislature.

Costs of administration.

ADMINISTRATIVE REGIONS

26. (1) For the economic and effective administration of public health services and of health insurance, the province shall be divided into areas to be known, for public health purposes, as "Public Health Regions" and, for health insurance purposes as "Health Insurance Regions".

Province divided into Public Health Regions and Health Insurance Regions.

(2) Within each such region there shall be established a unified administration of all public health services under the public health authority of the province, and of health insurance under the Commission, with such provision for co-operation between the administrations aforesaid in each region as may be deemed necessary and advisable in the interests of public health.

Unified administration of public health and health insurance.

(3) Before settling upon the areas to be included in any region, consideration shall be given to

Factors to be considered in establishing region.

- (a) the boundaries of the local government areas and of the school district areas;
- (b) the provision already made for public health services by the authorities within such areas;
- (c) the sufficiency of the population within any proposed region for the economic development of adequate public health services;
- (d) the natural sources of water supply and the drainage needs, both immediate and prospective;
- (e) the lines of communication to and within each proposed region;
- (f) the hospital facilities and the location thereof within each proposed region and adjoining regions;

- (g) the relation of each proposed region with adjoining regions and the regions as a whole; and
 (h) all other factors deemed to have a bearing on the determination of suitable regions for the purposes aforesaid.

Determi-
nation of
boundaries
of regions.

(4) Subject to the provisions of this section, the boundaries of the regions shall be settled upon by such authority of the province as may be designated by the Lieutenant-Governor in Council for that purpose, in consultation with the public health authority of the province and the Commission.

Proceedings
for effecting
utilization
of existing
facilities.

(5) The said authorities and the Commission in consultation with representatives chosen by the local governments within any region, or proposed region, shall prepare a scheme for the apportionment among the several local governments within the region of that part of the costs of the public health services not otherwise provided for in this Act, and for the utilization for public health purposes within the region of the public health facilities and personnel of the local governments within the region, and shall submit the said scheme to the said local governments for consideration.

Arbitration
in case of
objection.

(6) In case any such local government files objection to the scheme with the said authorities and the Commission within . . . days after a copy of the scheme is delivered to the clerk of the local government, the scheme shall be submitted to arbitration for revision or for confirmation.

Composition
of arbitra-
tion body;
finality of
decision.

(7) The arbitrators shall consist of two representatives chosen by each of the authorities aforesaid, two persons chosen by the Commission, and two persons chosen by each local government within the area, together with a chairman chosen by the Lieutenant-Governor in Council, and the decision of a majority of the arbitrators shall be final.

Re-examina-
tion of scheme
at instance of
health
authorities
and periodi-
cally at
instance
of local
authority.
Regulations
for making
effective
this section.

(8) The scheme for the apportionment of costs may be re-examined and a new scheme prepared by the said authorities at any time at the instance of the public health authority, or at the end of each five-year period at the instance of any local government within the region, subject to arbitration as aforesaid.

(9) The Commission may make all regulations necessary to make effective the intentions of this section and the provisions aforesaid shall be subject to the terms and provisions of those regulations.

Regional and
Divisional
offices.

27. (1) The Commission shall establish an office (to be called a Regional Office) within each Health Insurance Region and may divide any region into such number of divisions (each with an office to be called a Divisional Office) as may be deemed necessary for the purposes of this Act.

(2) The Divisional officers in any region shall be under the general control, supervision and direction of the regional office.

(3) The organization, duties and responsibilities of each divisional office shall be as prescribed.

28. (1) In addition to the officers and staff which may be established in any region, there shall be in each region an officer of the Commission to be known as the Regional Medical Officer and such number of Assistant Regional Medical Officers as the Commission may from time to time determine to be necessary for the purposes of this Act.

Regional
Medical
Officers.

(2) Regional Medical Officers and Assistant Regional Medical Officers may be employed on a full-time or part-time basis as the circumstances in each region may require, and their salaries shall be paid out of the Fund.

Employment
and remuneration.

(3) Subject to any regulations made hereunder, the duties and responsibilities of the Regional Medical Officer shall be

(a) to advise practitioners in the discharge of their duties under this Act;

(b) to keep in touch with practitioners with the object of raising the standards of service under the Act;

(c) to examine and satisfy himself of the accuracy and sufficiency of the clinical and other records of practitioners and hospitals;

(d) to investigate any case of alleged excessive prescribing of drugs, medicines, materials or appliances by any practitioner; and

(e) to perform such other duties and to assume such further responsibilities as may be prescribed.

REPRESENTATIVE COMMITTEES

29. (1) For the purposes of consultation concerning the terms of any regulations made or to be made under sections eleven, twelve, thirteen, fourteen and fifteen hereof, and the making of the arrangements referred to in those sections with hospitals, or with the members of any profession, for supplying benefits under this Act, the Commission may recognize any committee which satisfies the Commission that it is representative of hospitals, or of the members of any of the said professions, and authorized or constituted to promote and safeguard the interests of hospitals, or of the members of any of the said professions, as the case may be, concerning the operations of this Act, and upon being so recognized the said committee shall be deemed to be a committee appointed for the purposes mentioned in this subsection.

Committees
representative of
hospitals
and of the
professions
supplying
benefits.

Power of Commission to secure election of committee or appoint one.

(2) If at any time the Commission is not satisfied concerning the matters aforesaid as to any committee, or in default of such a committee with respect to hospitals or the members of any profession as the case may be, the Commission shall in manner prescribed secure the election of a Committee or, on failure so to do, appoint a Committee for the purposes mentioned in the last preceding subsection.

Recognition by Commission of specially appointed committee of profession organized by statute.

(3) Notwithstanding anything hereinbefore in this section contained, and subject to the next following subsection, if the members of any profession are organized by virtue of a statute of the province applicable to the members of that profession, then the executive body of that organization, under whatever title that body may be styled, shall have power to appoint a committee for the purposes mentioned in subsection one of this section, from the members of that organization, including the members of the said executive body, and the Commission shall, subject to the receipt of evidence of the said appointment, recognize the committee so appointed for such purposes.

Application to dentists and pharmacists only.

(4) Unless otherwise prescribed the provisions of the last preceding subsection shall apply only to the members of the dental profession and of the pharmaceutical profession.

Power of Commission to recognize, secure election of or appoint regional committee.

(5) Where the interests of the hospitals, or of the members of any of the aforesaid professions, in a particular region or area are concerned, rather than for the province as a whole, the Commission, in consultation with the relevant committee for the province as a whole, may in manner prescribed, recognize, secure the election of, or appoint, as the circumstances may require, a committee in that region or area for the purposes mentioned in subsection one of this section.

General consultative, advisory, administrative, or executive committees or councils.

30. (1) In addition to the powers elsewhere in this Act conferred upon the Commission to establish committees for the purposes of this Act, by regulation made hereunder the Commission may, in any region or area or for the province as a whole, establish such committees, councils, or other bodies or instrumentalities, as may be deemed advisable, for consultative, advisory, administrative or executive purposes or for the purpose of securing effective co-operation in the administration of this Act and of any other Act concerned with the conservation of health or with public welfare.

Constitution, duties, etc., of committee.

(2) The constitution, duties, powers, and procedure of each such committee, council, or other body or instrumentality shall be as prescribed in the regulations.

DETERMINATION OF QUESTIONS

- 31.** (1) If any question arises as to the right of any person to receive a benefit, the question shall be determined by the Commission, or by a person appointed by the Commission for that purpose, in accordance with regulations made in that behalf. Determina-
tion of
questions
concerning
the rights of
persons.
- (2) If any person is aggrieved by a decision made as hereinbefore in this section provided, he may appeal in the prescribed manner on a question of law to a judge in chambers, and the decision of that judge shall be final. Appeal from
decision of
Commission.
- (3) The Commission may, on motion, apply to the Superior Court of the province for the opinion, advice, or direction of the Court on any question of law relating to the operation of this Act. Power to
apply to court
for opinion,
advice, or
direction
on law.
- (4) Any person appointed in accordance with the regulations made under this section for the purpose of holding an inquiry and reporting to the Commission may by summons require any person to attend, at such time and place as is set forth in the summons, to give evidence or to produce any documents in his custody or under his control which relate to the question to be determined, and may take evidence on oath and for that purpose administer oaths: Provided that no person shall be required, in obedience to such summons, to go more than ten miles from his place of residence unless the necessary expenses of his attendance are paid or tendered to him. Power to
require
attendance
and evidence
of witness and
production of
documents.
- (5) Every person who refuses or wilfully neglects to attend in obedience to a summons issued under this section or to give evidence, or who refuses to produce any book or document which he may be required to produce for the purposes of this section, shall be liable on summary conviction to a fine not exceeding twenty-five dollars. Proviso.
- (6) The Commission may, on new facts being brought to their notice, revise any decision given by them under this section, other than a decision against which an appeal is pending or in respect of which the time for appeal has not expired, and an appeal shall lie against any such revised decision in the same manner as against an original decision. Penalty on
person for
failure to
attend, give
evidence, etc.
- (7) Provision may be made by rules of the Court for regulating appeals under this section, and those rules shall provide for limiting the time within which an appeal under this section may be brought, and for the determining in a summary manner of any such appeals and for requiring notice of any such appeal to be given to the Commission. Power to
revise
decisions.
- (8) The Commission shall be entitled to be represented and to be heard on any appeal under this section. Rules
regulating
appeals.
- Right of
Commission
on appeal.

INVESTIGATIONS OF COMPLAINTS AND DISPUTES; APPEALS

Regulations
for procedure
as to investi-
gation of
complaints
and disputes.

32. (1) Regulations may be made hereunder prescribing the manner in which complaints or disputes may be filed with the Commission for investigation as hereinafter in this section provided.

(2) For the purpose of investigating any complaint made by

(a) any person who is or was, or who claims to be or to have been, a qualified person, or on behalf of any such person, against

(i) any person, or hospital, concerned in supplying any benefit or service to qualified persons, or

(ii) the Commission or any officer or person acting on behalf of the Commission; or

(b) any person, or hospital, concerned in supplying any benefit or service to qualified persons, against

(i) any other such person or hospital,

(ii) any person who is or was a qualified person, or

(iii) The Commission or any officer or person acting on behalf of the Commission; or

(c) the Commission against

(i) any person who is a qualified person, or

(ii) any person, or hospital, concerned in supplying any benefit or service to qualified persons;

Power to
establish
committees
to investigate
disputes.

and also for the purpose of investigating a dispute between any of the parties aforesaid, the Commission shall by regulation made hereunder establish such committees, whether for the province as a whole or for regions or areas, as may seem desirable, and the constitution, duties, powers, and procedure of each such committee shall be as prescribed in the regulations.

Reference of
complaints
and disputes
to com-
mittee.

(3) In any case in which

(a) a person who is or was, or who claims to be or to have been a qualified person, or a person on behalf of any such person; or

(b) a person with whom arrangements have been made under the provisions of this Act for supplying any benefits or service to qualified persons; or

(c) a hospital; or

(d) the Commission,

is concerned in a complaint or is a party to a dispute, the regulations aforesaid shall provide that the complaint or the dispute shall be referred to a committee which shall, apart from the Chairman, be composed of members chosen in manner prescribed in equal numbers from, respectively,

Composition
of com-
mittee.

(i) qualified persons, if a qualified person is concerned in the complaint or is a party to the dispute;

(ii) the members of the profession of the person referred to in paragraph (b) of this subsection, if any

such person is concerned in the complaint or is a party to the dispute;

(iii) a panel of persons named as prescribed for the purposes of this section as respects hospitals, if a hospital is concerned in the complaint or is a party to the dispute;

(iv) a panel of persons named as prescribed for the purposes of this section as respects the Commission, if the Commission is concerned in the complaint or is a party to the dispute.

(4) The regulations shall prescribe the classes of cases which may be settled by the Commission on the basis of the findings and recommendation of the committee to which the dispute or complaint is referred for investigation and the classes of cases in which an appeal may be made from the findings of the committee and the nature of the appeal: Provided that provision for appeal shall be made in all cases where the right of any person, or hospital, to continue to supply any benefit or services under this Act is in question.

Regulations for prescribing cases to be settled on findings of committee; classes of cases which may be appealed.

Proviso.

(5) The regulations shall provide that all appeals referred to in the proviso to the last preceding subsection shall be referred by the Commission to an appeal committee consisting of a barrister-at-law or a solicitor and at least two persons, selected as prescribed by regulation, from qualified persons or from the profession of the person concerned or from representatives of hospitals, as the case may be, and the Commission shall, in manner prescribed, give effect to the recommendations of that committee.

Appeal Committee, composition of, and effect of recommendations thereof.

(6) For the purpose of consultation concerning the terms of regulations made or to be made under this section, the relevant provisions of section twenty-nine of this Act shall apply.

Consultation, sec. 29 applicable.

(7) For the purposes of setting up a committee under this section, "committee" may include a subcommittee of a committee established under this Act.

Sub-committee.

INSPECTION

33. (1) Any person authorized by the Commission to act as an inspector shall, for the purpose of the execution of this Act, have power

Powers of the Inspectors.

(a) to enter at all reasonable times any premises or place, other than a private dwelling-house not being a workshop, wherein he has reasonable grounds to suppose that persons are employed and to make examination and inquiry as may be necessary for ascertaining whether the provisions of this Act are complied with in any such premises or place;

(b) to examine orally, either alone or in the presence of any other person, as he thinks fit, with respect to any matters under this Act, every person whom he

finds in any such premises or place, or whom he has reasonable cause to believe to be or to have been an employed person, and to require every such person to be so examined and to sign a declaration of the truth of the matters in respect of which he is so examined; and

(c) to do such other things as may be necessary or as are prescribed for carrying this Act into effect.

Occupier
to furnish
information
to inspector
and produce
books.

(2) The occupier of any such premises or place and any other persons employing any person, and the servants and agents of any such occupier or other person and any such employee shall furnish to any inspector all such information and shall produce for inspection all such registers, books, cards, wage sheets, records of wages and other documents as the inspector may reasonably require.

Inspection by
officers of
other depart-
ments or
governments.

(3) Where any such premises or place is liable to be inspected by inspectors or other officers of, or is under the control of, some other branch or department of the government of the province or of some other province or of the Government of Canada, the Commission may make arrangements with the authority in control of the inspection, or in control of any branch or department, as aforesaid, for the carrying out of any of the powers and duties of inspectors under this section by inspectors or other officers of the authority aforesaid, and where such an arrangement is made, those inspectors and officers shall have all the powers of an inspector under this section.

Production
by inspector
of certificate
of appoint-
ment.

(4) Every inspector shall be furnished with the prescribed certificate of his appointment, and on applying for admission to any premises or place for the purpose of this Act shall, if so required, produce the said certificate to the occupier.

Penalty for
delay or
obstruction
of inspection.

(5) If any person wilfully delays or obstructs an inspector in the exercise of any power under this section or fails to give such information or to produce such documents as required in this section, or conceals or prevents or attempts to conceal or prevent any person from appearing before or being examined by an inspector, he shall be guilty of an offence against this Act and liable on summary conviction to a fine not exceeding twenty-five dollars.

Incriminating
questions.

(6) No person shall be required under this section to answer any question or give any evidence tending to incriminate himself.

OFFENCES, LEGAL PROCEEDINGS, ETC.

Penalty
for false
representa-
tion.

34. If for the purpose of obtaining any benefit or payment under this Act, either for himself or for any other person, or for the purpose of avoiding any payment to be made by himself under this Act, or enabling any other

person to avoid any such payment, any person knowingly makes any false statement or false representation, he shall be guilty of an offence against this Act and liable on summary conviction to imprisonment for a term not exceeding three months, with or without hard labour.

35. If any person wilfully contravenes, fails or neglects to comply with any of the requirements of this Act or the regulations made thereunder in respect of which no penalty is provided, or fails or neglects to pay any contribution for which he is liable under this Act, he shall be guilty of an offence against this Act and for each such offence be liable, on summary conviction, to a fine not exceeding two hundred and fifty dollars, or to imprisonment for a period not exceeding three months, or to both fine and imprisonment:

Provided that in any case where a person is convicted of the offence of failing or neglecting to pay a contribution there shall be imposed on him, in addition to the aforesaid penalty, a further penalty equal to the amount of the contribution which he has failed or neglected to pay, which additional penalty shall be paid over to the Health Insurance Fund.

36. (1) Every person who buys, sells, or offers for sale, takes or gives in exchange or pawns or takes in pawn, any insurance card, insurance book, or used health insurance stamp, or any document or thing used in the administration of this Act, or has in his possession any of these things, not being entitled to possess them, shall be guilty of an offence against this Act and for each such offence shall be liable on summary conviction to a fine not exceeding two hundred and fifty dollars or to imprisonment for a term not exceeding three months, or to both fine and imprisonment.

(2) For the purposes of this section an insurance stamp shall be deemed to have been used if it has been cancelled or defaced in any way whatever and whether it has been actually used for the purpose of the payment of the contribution or not.

37. (1) Proceedings for an offence under this Act shall not be instituted except with the consent in writing of the Commission or by an inspector or other officer appointed under this Act and authorized in that behalf by special or general directions of the Commission.

(2) Proceedings for an offence under this Act may be commenced at any time within three months from the date on which evidence, sufficient in the opinion of the Commission to justify a prosecution for the offence, comes to their knowledge, or within twelve months after the offence, whichever period is the longer.

Penalty for contravention or non-compliance.

Additional penalty.

Penalty for sale or improper use of insurance books, cards, stamps, etc.

When stamps deemed to have been used.

Power to take and conduct proceedings.

To be commenced within three months of evidence of offence.

Certificate of
Commission
evidence
of date.

(3) For the purpose of this section, a certificate issued by the Commission as to the date on which such evidence came to their knowledge shall be conclusive evidence thereof.

Sums due
recoverable
as civil
debts.

Proviso.

38. Any sum due and owing to the Fund under this Act shall be recoverable as a debt due to the Crown in the right of the province and, without prejudice to any other remedy, may be recovered by the Commission as a civil debt: Provided, however, that proceedings for the recovery of the same shall not be brought except within three years from the time when the same shall have become due and owing.

Civil
proceedings
by employee
against
employer
for neglect
to comply
with the Act.

39. (1) Where any employer fails or neglects to comply, in relation to any person in his employment, with the requirements of any regulations relating to the payment and collection of contributions, and by reason thereof that person is not qualified to receive a benefit which he would have been qualified to receive but for that failure or neglect, the Commission may either supply that person with that benefit or pay him the value of the benefit he has so lost, as the circumstances of the case may require, and shall recover from the employer as a civil debt a sum equal to the value of the benefit so supplied or the amount so paid.

Proceedings
may be
taken
within one
year.

(2) Proceedings under the preceding subsection of this section may be brought at any time within one year after the date on which any such person, but for the failure or neglect of the employer, would have been entitled to receive the benefit which he has lost.

Penalty for
receipt of
benefit
through non-
disclosure
or misrepres-
entation of
material fact.

(3) If it is found at any time that any person, by reason of the non-disclosure or misrepresentation by him of a material fact (whether the non-disclosure or misrepresentation was or was not fraudulent) has received any benefit while he was not qualified for receiving that benefit, he shall be liable to pay to the Fund a sum equal to the value of the benefit so received by him.

Additional
proceedings.

(4) Proceedings may be taken under this section notwithstanding that proceedings have been taken under any other provision of this Act in respect of the same failure or neglect.

Value of
benefit.

(5) Regulations may be made hereunder for determining the value of any benefit for the purposes of this section.

REGULATIONS

Regulations
on additional
matters.

40. (1) In addition to the authority elsewhere in this Act conferred upon the Commission to make regulations, the Commission may make regulations

Reference
of adminis-
tration
matters to
committees.

(a) governing the reference, for consideration and advice, of questions bearing on the operation of this Act to any committee established under this Act;

(b) prescribing the period for which contributions shall be paid by or on behalf of any person who moves into the province after such date as may be prescribed, and the other conditions to be complied with, before he shall be entitled to the benefits of this Act, and for prescribing any limitations in the said benefits applicable to such persons or to any class thereof;

Benefits for new residents.

(c) prescribing penalties for the violation of any regulation, including maximum and minimum fines: Provided, however, that a fine prescribed shall not exceed two hundred and fifty dollars nor shall a term of imprisonment exceed three months; and

Penalties for violation of regulations.

(d) generally for carrying this Act into effect.

(2) Any regulations made under this Act may contain such incidental, supplemental, or consequential provisions as appear necessary for modifying the provisions of this Act and any regulation may be varied or revoked by subsequent regulation made in like manner.

Modification of provisions of Act by regulations.

(3) All regulations made under this Act shall be without effect until approved by the Lieutenant-Governor in Council and published in the Gazette, and shall then have effect as if enacted in this Act and shall be submitted for ratification to the Legislative Assembly within two weeks after approval, or, if the Legislative Assembly is not then sitting, within two weeks after the Legislative Assembly next sits.

Approval and publication of regulations.

Amendment of regulations.

GENERAL

41. (1) Within one month after the thirty-first day of March in each year, or within such longer period as may be approved by the Lieutenant-Governor in Council, the Commission shall submit to the Minister a report covering the business and affairs of the Commission, for the twelve months ending on the said thirty-first day of March, in such detail as the Minister may from time to time direct; and such report shall contain a statement of the costs arising out of the administration of this Act, including the indirect costs as nearly as they may be ascertainable and also a statement of the services rendered to the Commission by other departments of the public service.

Duty of Commission respecting annual report to Minister.

(2) The Minister shall lay before the Legislative Assembly any such report within fifteen days after it is submitted to him or, if the Legislative Assembly is not then sitting, within fifteen days after the Legislative Assembly next sits.

Report to be laid before Legislature.

42. The Lieutenant-Governor in Council may direct the Commission to investigate and report upon all questions which the Lieutenant-Governor in Council may deem advisable or necessary.

Lieutenant-Governor in Council may require investigation and report.

Reports submitted through Minister.

43. All reports, recommendations and submissions required to be made under this Act to the Lieutenant-Governor in Council shall be submitted through the Minister.

Power of Commission to require returns by any person.

Penalty for failure.

44. The Commission may require any person to make written returns of information deemed by the Commission to be necessary for the purposes of this Act, and failure to comply with any such request shall be an offence against this Act and shall on summary conviction render liable any person in default to a fine not exceeding fifty dollars or to imprisonment for a period not exceeding one month, or to both fine and imprisonment.

Fines to province.

45. Any fine imposed under this Act or regulations made thereunder shall, unless otherwise provided for, be payable to His Majesty in the right of the province and be disposed of as the Lieutenant-Governor in Council may direct.

Power of Lieutenant-Governor in Council to make reciprocal agreements.

R.S.C., c. 98.

46. The Lieutenant-Governor in Council may, notwithstanding anything herein contained, enter into agreement with the government of another province or country to establish reciprocal arrangements on questions relating to health insurance and with the government of Canada on questions relating to health insurance for Indians as defined in the *Indian Act*, chapter ninety-eight of the Revised Statutes of Canada, 1927.

Audit of accounts.

47. The accounts of the Commission shall be subject to the applicable provisions of the Audit Act.

Contributions payable when prescribed by Commission.

48. No contribution shall be payable or paid under the provisions of this Act until a date to be prescribed by the Commission of which due notice shall be published in the Gazette and in such other manner as the Commission may deem necessary.

THIRD SCHEDULE

(Section 5)

PUBLIC HEALTH SERVICES:

I. PREVENTIVE

For the control of communicable diseases and for the free distribution of vaccines and sera and other biological preparations for prevention and treatment.

II. CONSULTIVE

To provide consultive technical advisory assistance for the prevention and control of communicable diseases.

III. EDUCATIONAL

For education in the field of public health, including the organization of local voluntary agencies for the dissemination of educational information through literature, lectures, radio and other measures.

IV. MENTAL HYGIENE

Including psychiatric clinics for early diagnosis; and to co-operate with the Department of Education in the provision of educational classes for mentally retarded and mentally defective children.

V. FOOD AND DRUG CONTROL

For the supervision of premises, equipment and personnel used for the manufacture and distribution of foods, drugs and biological preparations.

VI. NUTRITION

To carry on research and educate the public in regard to nutritive values of foods.

VII. LABORATORY

To extend existing laboratories.

VIII. SANITATION

To supervise and direct all measures related to the provision of adequate sanitation.

IX. VITAL STATISTICS

To collect and disseminate all information relating to births, marriages and deaths; to collect morbidity and mortality reports of communicable diseases relating to any health insurance plan that may be adopted by the province; and to publish an annual report analysing the deaths and various factors related thereto.

X. HOSPITALS AND SANATORIA

For the supervision of hospitals and sanatoria.

XI. DENTAL HYGIENE

To provide dental inspection for school children both in urban and rural areas and for the adoption of corrective measures through co-operation with the Health Insurance Authority; to extend travelling clinics to provide remedial treatment in remote districts both in respect of adults and children; and to extend existing dental clinics.

XII. CHILD AND MATERNAL HYGIENE

Under the direction of one or more specialists to institute recognized and accepted procedures for the reduction of infant and maternal mortality.

XIII. INDUSTRIAL HYGIENE

To supervise environmental sanitation and all factors relating to the health and welfare of industrial and other workers.

XIV. QUARANTINE

To adopt measures to prevent entrance into and the dissemination of communicable diseases within the province.

XV. PUBLIC HEALTH NURSING

As may be necessary for the prevention and treatment of communicable diseases and the supervision of sanitation in relation to the home, as well as the enforcement of quarantine measures; to assist the family in the application of sanitary and social measures and generally in the promotion of health.

XVI. HOUSING

To supervise sites, plans and construction of houses.

XVII. VENEREAL DISEASE

For venereal disease control.

XVIII. TUBERCULOSIS

For the prevention of tuberculosis in co-operation with the Health Insurance Authority.

XIX. CANCER

To provide for early diagnosis and treatment and to conduct an educational programme.

XX HEART

For the prevention and early detection of heart disease in children.

XXI. SCHOOL HEALTH

For the medical inspection of school children in all parts of the province for the detection and control of diseases and for the prevention and correction of physical defects.

XXII. EPIDEMIOLOGY

To provide personnel for the purpose of directing all studies and investigations respecting the prevention and control of disease.

XXIII. RESEARCH

To conduct scientific research in relation to diseases.

Government
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